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

THURSDAY, NOVEMBER 5, 2026
2:00 P.M.

505 CITY PARKWAY WEST
ORANGE, CALIFORNIA 92868

TELECONFERENCE LOCATION FOR
DIRECTOR ISABEL BECERRA
1819 OCEAN AVENUE
SANTA MONICA, CA 90401

BOARD OF DIRECTORS

Supervisor Vicente Sarmiento, Chair
Maura Byron, Vice Chair
Isabel Becerra
Blair Contratto
Norma Garcia Guillen
Catherine Green, R.N.
Brian Helleland
Veronica Kelley, DSW, LCSW
(Vacant)
Supervisor Janet Nguyen

Supervisor Doug Chaffee, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	Tina Knapp

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. Please complete a Public Comment Request Form and submit to the Clerk of the Board. 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.

Your participation is always welcome. Specific information as to how to participate in this meeting is detailed in the Notice Regarding Public Attendance & Participation at Public Meetings attached to this agenda. In general, CalOptima Health offers several ways in which to interact during this meeting: you may participate in person, join the meeting live on your computer or similar device, and/or listen to the meeting via telephone.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS

1. State Advocacy Update - Clear Advocacy

MANAGEMENT REPORTS

2. Chief Executive Officer Report

3. Chief Financial Officer Report

4. Transition of Unsatisfactory Immigration Status Members to Fee-for-Service Medi-Cal

ADVISORY COMMITTEE UPDATES

5. Member Advisory and Provider Advisory Committees Report to the Board

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

6. Meeting Minutes

Recommended Action:
A. Approve Minutes of the October 1, 2026 Regular Meeting of the CalOptima Health Board of Directors
B. Receive and File Minutes of the June 18, 2026 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

7. Approve the CalOptima Health Measurement Year 2027 Medi-Cal and OneCare Pay for Value Programs

Recommended Action:
1. Approve CalOptima Health Measurement Year 2027 Medi-Cal Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
2. Approve CalOptima Health Measurement Year 2027 OneCare Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.

3. Approve the Measurement Year 2027 CalOptima Health Community Network Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
4. Approve the Measurement Year 2027 Shared Risk Pool Quality Measures effective January 1, 2027, through December 31, 2027.

8. Approve the Measurement Year 2027 CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program

Recommended Action:

Approve the Measurement Year 2027 Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program, effective January 1, 2027, through December 31, 2027.

9. Approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program

Recommended Action:

Approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program for Medi-Cal and OneCare, effective January 1, 2027, through December 31, 2027.

10. Approve Actions Related to Implementation of a Quality Improvement Pilot Program

Recommended Action:

1. Authorize CalOptima Health staff to conduct a non-competitive, by-invitation-only, notice of funding opportunity related to the Quality Improvement Grant Pilot Program, administer grant agreements, and release award payments to the participating entities.
2. Authorize allocation of up to $500,000 from the CalOptima Health Community Care Network component of the Measurement Year 2025 Pay-for-Value Program for the Quality Improvement Grant Pilot Program.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

11. Approve New CalOptima Health Policy: GG.1640 and Approve Modifications to CalOptima Health Policies: GG.1611, GG.1615, GG.1616, GG.1650, and GG.1651

Recommended Action:

Approve CalOptima Health Policy GG.1640: Health Network Pay for Value (P4V) Program and approve revisions to the following existing CalOptima Health policies:

- Policy GG.1611: Potential Quality Issue Review Process;
- Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues;
- Policy GG.1616: Fair Hearing Plan for Licentiates;
- Policy GG.1650: Credentialing and Recredentialing of Practitioners; and
- Policy GG.1651: Assessment and Reassessment of Organizational Providers.

12. Approve New CalOptima Health Policies: CC.1401: Authorization and Monitoring of Behavioral Health Treatment Services, CC.1402: Transcranial Magnetic Solution, and CC.1403: Electroconvulsive Therapy

Recommended Action:

Approve the following new CalOptima Health behavioral health policies and procedures related to the CalOptima Health Covered California product:

1. CalOptima Health Policy CC.1401: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services;
2. CalOptima Health Policy CC.1402: Transcranial Magnetic Solution (TMS); and
3. CalOptima Health Policy CC.1403: Electroconvulsive Therapy.

13. Adopt Resolution No. 26-1105-01 Approving the Proposed 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; 2027 CalOptima Health Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Program; and Revised Office of Compliance Policies and Procedures

Recommended Action:

Adopt Resolution No. 26-1105-01 approving:

a. Proposed 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, and Abuse Plan; and 2027 CalOptima Health Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Program; and
b. Revised CalOptima Health Office of Compliance Policies and Procedures:
   i. CalOptima Health Policy HH.3001: Member Access to Designated Record Set
   ii. CalOptima Health Policy HH.3014: Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)
   iii. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
   iv. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII, or Other Unauthorized Use or Disclosure of PHI/PII
   v. CalOptima Health Policy HH.3023: Information Sharing
   vi. CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal)
   vii. CalOptima Health Policy HH.4004: Grant Audits/Reviews

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

Recommended Action:

Authorize and direct the Chair of the CalOptima Health Board of Directors to execute Amendment 03 to the Primary Contract and Amendment 02 to the Companion Contract for the Program of All-Inclusive Care for the Elderly between the California Department of Health Care Services and CalOptima Health.

15. Approve New Long Term Services and Support Policy CC.2200

Recommended Action:

Approve a new CalOptima Health Policy CC.2200: CalOptima Health Hospice Coverage, Notification and Validation Requirements to reflect clinical operational requirements for CalOptima Health's Covered California product, effective January 1, 2027.

16. Approve CalOptima Health Finance Policies

Recommended Action:

1. Approve revisions to the following existing CalOptima Health Finance Policies, effective January 1, 2027:
   a. CalOptima Health Policy FF.1006: Financial Risk Arrangements;
   b. CalOptima Health Policy FF.1010: Shared Risk Pool; and
   c. CalOptima Health Policy MA.3003: Medicare Shared Risk Pool.
2. Approve new CalOptima Health Policy FF.4003: Vendor Exclusion and Preclusion Monitoring, effective November 5, 2026.

17. Authorize Funding for Independent Audit Services Pursuant to Assembly Bill 2194

Recommended Action:

Authorize unbudgeted expenditures in an amount up to $2.0 million from undesignated reserves to fund an independent, external audit of CalOptima Health's governance procedures and practices, pursuant to Section 14087.591 of the Welfare and Institutions Code, as amended and added by Assembly Bill 2194 (2026).

18. Authorize Amendments to the CalOptima Health Ancillary Services Contracts with Community Supports Providers, the Orange County Health Care Agency, and Applicable Medi-Cal Shared Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Network Contracts for the Medi-Cal Program

Recommended Action:

Authorize the Chief Executive Officer, or designee, to execute amendments to revise Enhanced Care Management payment rates and frequency of services, in accordance with Department of Health Care Services requirements, with CalOptima Health Community Supports providers, the Orange County Health Care Agency, and applicable Medi-Cal Shared Risk Group, Physician-Hospital Consortium, and Health Maintenance Organization health networks, effective December 1, 2026.

19. Status Report on Enhanced Care Management Benefit for Medi-Cal Members

Recommended Action:

Accept, receive, and file a Status Report on Enhanced Care Management benefit for Medi-Cal Members.

20. **Status Report on the Community Health Worker Benefit for Medi-Cal Members**

Recommended Action:

Accept, receive, and file a Status Report on the Community Health Worker Benefit for Medi-Cal Members.

21. **Authorize Amendments to the CalOptima Health Shared Risk Group Health Network Contracts Regarding the Shared Risk Pool Programs for the Medi-Cal, OneCare, and Covered California Programs**

Recommended Action:

Authorize the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health Shared-Risk Group Health Network Contracts, effective January 1, 2027, to ensure alignment with CalOptima Health Policies

22. **Adopt Resolution No. 26-1105-02 Approving Updated and New CalOptima Health Human Resources Policies**

Recommended Action:

Adopt Resolution No. 26-1105-02 Approving Updated and New CalOptima Health Human Resources policies, effective November 5, 2026:

1. Updated CalOptima Health Policy GA.8018: Paid Time Off (PTO);
2. Updated CalOptima Health Policy GA.8042 Supplemental Compensation; and
3. New CalOptima Health Policy GA.8065: Paid Time Off (PTO) Donation Policy

23. **Receive and File – Strategic Plan Performance Executive Status Report, July - September 2026**

24. **Receive and File – Monthly Financial, Compliance, Government Affairs, and Member Grievances Reports**

A. September 2026 Financial Summary
B. Compliance Report
C. Government Affairs Reports
D. Member Grievances and Appeals Quarterly Report

25. **Receive and File – September & October Monthly Community Events and Sponsorship Reports**

A. CalOptima Health Community Outreach Summary
B. Sponsorships & Community Participation Including Upcoming Events

DISCUSSION ITEMS

26. Approve Actions Related to the Provider Workforce Development Initiative to Pilot a Provider Recruitment Incentive Program

Recommended Action:

1. Authorize an allocation of up to $5 million from the $50 million restricted Provider Workforce Development Fund to support the previously approved Provider Recruitment Incentive Program.
2. Authorize the Chief Executive Officer, or designee, to administer the Provider Recruitment Incentive Program.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

27. Approve Material Changes to Grant Award Agreement with Orange County Health Care Agency for the Community Health Assessment and Community Health Improvement Plan

Recommended Action:

1. Approve material changes and amend the Grant Award Agreement with Orange County Health Care Agency related to the Community Health Assessment and Community Health Improvement Plan to do the following:
   a. Extend the Grant Award Agreement by 24 months through December 31, 2028, for a total term of 36 months;
   b. Add scopes of work for years two and three of the grant term; and
   c. Increase the grant award up to $904,465 for year two and up to $920,705 for year three.
2. Appropriate and allocate up to $1,825,170 in existing reserves to fund the amendment to the Grant Award Agreement with Orange County Health Care Agency through December 31, 2028.
3. Make a finding that such expenditures are for public purposes and in furtherance of CalOptima Health's mission and purpose.

28. Approve Extension of the Skilled Nursing Facility Access Program

Recommended Action:

1. Authorize a three (3)-year extension of the Skilled Nursing Facility Access Program through June 30, 2029.
2. Authorize the use of remaining funds from the SNF Access Program to continue the incentives program and lease beds in SNF and subacute facilities.
3. Authorize the Chief Executive Officer to contract with SNF and subacute facilities to increase bed capacity and facilitate transitions to lower levels of care.

CLOSED SESSION

CS-1 PUBLIC EMPLOYEE APPOINTMENT – GOVERNMENT CODE SECTION 54957(b)(1)
General Counsel

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NOTICE REGARDING
PUBLIC ATTENDANCE & PARTICIPATION AT PUBLIC MEETINGS
Board of Directors Meeting
Thursday, November 5, 2026
2:00 p.m.

Your participation is always welcome. CalOptima Health offers several ways in which to interact during meetings. You will find information as to these opportunities below.

IN-PERSON MEETING ATTENDANCE

You may attend the meeting in-person at the following location:

CalOptima Health
505 City Parkway West
Orange, CA 92868

LIVE AUDIO & VIDEO STREAMING (INCLUDING PUBLIC COMMENT CAPABILITY)

You may join the meeting live on your computer or similar device by using the link below:

Register for the Meeting
Webinar ID: 916 5739 7919
Passcode: 242275

If you register to make a public comment upon entering the Zoom meeting, you will be called upon at the appropriate time to make your comment. If you are unable to register to make a public comment, you may use the Q&A function of Zoom to make a public comment under the Public Comment portion of the meeting or during the discussion of any specific agenda item.

LIVE AUDIO & VIDEO STREAMING (NO PUBLIC COMMENT CAPABILITY)

The meeting will be available to listen and watch via the link below. This option does not include the ability to make public comment during the meeting.

Listen to & Watch the Meeting Online

PARTICIPATE IN THE MEETING BY TELEPHONE

Join via audio only using one of the following telephone numbers. When prompted, enter the Webinar ID and Passcode.

+1 669 900 6833	+1 689 278 1000	+1 360 209 5623
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+1 253 215 8782	+1 301 715 8592	+1 507 473 4847
+1 346 248 7799	+1 305 224 1968	International Numbers
+1 564 217 2000	+1 309 205 3325	
+1 646 931 3860	+1 312 626 6799	

Webinar ID: 916 5739 7919
Passcode: 242275

For any questions, please contact the CalOptima Health Clerk of the Board's office at 714-246-8806. Thank you for your interest in CalOptima Health!

CalOptima Health Board of Directors Meeting
November 5, 2026

Presentations Item 1: State Advocacy Update - Clear Advocacy Presentation is Forthcoming

October 30, 2026

Back to Agenda

MEMORANDUM

DATE:	November 5, 2026
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — November 5, 2026, Board of Directors Meeting
COPY:	Tina Knapp, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Covered California Monthly Update

CalOptima Health is continuing to prepare to launch a Covered California plan, effective January 1, 2027. Staff is currently focused on operational implementation activities in preparation for the open enrollment period beginning on November 1. Current Covered California enrollees have been able to renew their coverage and switch plans since October 1, and CalOptima Health has received enrollments through this process. Staff members are conducting daily meetings to monitor all readiness activities. In addition, open enrollment marketing and advertising campaigns were launched across multiple media platforms, and staff are supporting member and broker audiences with educational materials in advance of open enrollment. Since receiving provisional approval from the Department of Managed Health Care (DMHC) on August 11 for our Knox-Keene Act license material modification, staff is continuing to address final pending items within the DMHC filing. Further, staff is engaging with Covered California's contract managers, and system testing between Covered California and CalOptima Health is nearly complete.

B. DHCS Publishes UIS Medi-Cal FFS Transition Toolkit

The Department of Health Care Services (DHCS) has published a Medi-Cal Fee-for-Service (FFS) Provider Toolkit ahead of the January 1, 2027, transition of Medi-Cal members with unsatisfactory immigration status (UIS) from managed care to FFS. The toolkit includes information about provider enrollment and revalidation, eligibility verification, billing and claims processes, Treatment Authorization Requests, transportation services, continuity of care, and other resources to support providers. It will be updated periodically as additional guidance, resources and operational information become available. Providers and stakeholders are encouraged to review and share the toolkit and check the DHCS website for future versions to help ensure readiness and minimize disruptions in care for impacted members.

C. DHCS Releases Draft H.R. 1 Work Requirement Guidelines

On October 13, DHCS released a draft revised All County Welfare Directors' Letter (ACWDL) to provide counties with updated guidance on implementing the Work and Community Engagement Requirements (WCER), effective January 1, 2027, pursuant to H.R. 1. This guidance now incorporates

the provisions in the Centers for Medicaid & Medicare Services (CMS) Interim Final Rule issued on June 1, 2026. CalOptima Health is still awaiting separate guidance issued directly to Medi-Cal managed care plans, such as an All Plan Letter (APL), regarding our responsibilities related to WCER implementation. In the meantime, one of CalOptima Health's state associations, the California PACE Association, sent a letter to DHCS requesting that PACE participants be automatically and specifically exempted from the WCER. Since every PACE participant has already been determined by DHCS to meet a nursing facility level of care as a condition of PACE eligibility, this existing state determination should provide a clear and efficient pathway for identifying PACE participants as exempt, without requiring them or PACE organizations to navigate an additional verification process.

D. Governor Signs CalOptima Health Governance Bill

On September 27, Governor Gavin Newsom signed into law Assembly Bill (AB) 2194, introduced by State Assemblymember Avelino Valencia, which includes the following two major provisions impacting CalOptima Health's governance:

1. Implements staggered terms on the CalOptima Health Board of Directors for the seven seats with four-year terms (i.e., all regular seats except those held by the two Orange County supervisors and the nonvoting director of the Orange County Health Care Agency), in order to improve the continuity of CalOptima Health's governance. Effective for the next terms expected to begin in August 2028, the following three seats will be subject to initial, transitional two-year terms at that time:
    a. Community clinic representative
    b. Practicing licensed medical provider who is not affiliated with a health network
    c. Accounting or public finance professional or actively licensed attorney
2. Requires an independent, external audit of CalOptima Health's governance procedures and practices, with a final audit report to be submitted to the California State Legislature and DHCS by July 1, 2027.

Staff is now in the process of procuring a firm to conduct the audit in accordance with AB 2194.

E. 2026 Member and Population Health Needs Assessment Report Available for Review

In partnership with NORC at the University of Chicago, CalOptima Health has completed our Member and Population Health Needs Assessment. Conducted from mid-2025 to mid-2026, this comprehensive assessment brought together voices from members, providers, focus groups and interviews, along with administrative data and publicly available county reports and assessments. The final report provides insights into the strengths of our current health plans, provider network and initiatives, as well as opportunities for CalOptima Health and our provider and community partners to further support Orange County's vulnerable populations.

F. CalOptima Health Staff Visit Washington for Meetings With Congressional Staff

At the end of September, Government Affairs and Strategic Development leaders traveled to Washington, D.C., for productive meetings with 16 key Congressional offices, including staff for nearly all members of Orange County's federal delegation, other California delegation members and major health care committees. CalOptima Health provided updates on our H.R. 1 implementation efforts, Covered California launch-readiness activities, and other recent initiatives, and advocated for our public policy priorities ahead of a busy lame-duck session following the midterm elections on November 3, when bipartisan health care legislation is likely to be considered. While in Washington, CalOptima Health leaders also attended the annual CEO Summit and Membership Council meetings hosted by one of our federal trade associations, the Association for Community Affiliated Plans. These

meetings included opportunities to hear from and interact with senior leaders at CMS about the future of Medicaid, Medicare and the Marketplace.

G. CalOptima Health Hosting Third Annual Thanksgiving Food Distribution on November 21

CalOptima Health is hosting our third annual Thanksgiving Food Distribution and Open House Event for members on Saturday, November 21, from 9 a.m. to 1 p.m. at our 505 building. Registered CalOptima Health members will receive a choice of a turkey, ham or gift card (for vegetarian options), along with traditional side items and an insulated cart. Nonmembers will receive free food boxes. Members can connect with various CalOptima Health departments to learn more about our Medi-Cal programs and the supportive services we offer. Medi-Cal and CalFresh enrollment assistance will be available, along with flu and COVID-19 vaccinations. We are expecting more than 1,000 families to attend this event.

H. Press Releases and Media Coverage

Over the past month, CalOptima Health distributed three press releases:

- On September 28, we issued a press release about NCQA rating us as a 4-star Medi-Cal plan.
- On October 1, we issued a press release about CalOptima Health distributing $8 million for nine Housing and Homelessness Incentive Program grants, which received coverage in the Orange County Business Journal.
- On October 19, CalOptima Health distributed a press release regarding the Board-approved $6.1 million for its newly named "Keep Your Medi-Cal, OC" initiative that will help members maintain health coverage as broad changes affect Medi-Cal starting January 1, 2027.

CalOptima Health

Fast Facts
November 2026

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

Membership Data* (as of September 30, 2026)

Total CalOptima Health Membership

788,667

Prior month: 794,688

Program	Members
Medi-Cal	768,948
OneCare (HMO D-SNP)	19,126
Program of All-Inclusive Care for the Elderly (PACE)	593

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

Key Financial Indicators (for the month ended September 30, 2026)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$3.3M	$36.5M	(110.0%)
Non-Operating Income/(Loss)	●	$10.7M	($13.8M)	(56.2%)
Covered California Start-up Expenses	●	($1.8M)	$2.0M	52.6%
Bottom Line (Change in Net Assets)	●	$12.2M	$24.8M	196.9%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	96.2%	---	(0.3%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	3.7%	---	3.1%

Notes: For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.

Reserve Summary (as of September 30, 2026)

	Amount (in millions)
Board Designated Reserves*	$1,632.7
Statutory Designated Reserves	$155.2
Capital Assets (Net of depreciation)	$127.4
Unspent Balance of Allocated Resources	$305.0
Unspent Balance of Board Approved Provider Rate Increase	
Increase from 7/1/24 – 12/31/26	$52.6
Increase from 7/1/26 – 12/31/28	$386.6
Unallocated Resources*	$467.9
Total Net Assets	$3,127.3

* Total Designated Reserves and Unallocated Resources can support about 176 days of CalOptima Health's current operations.

Notes: 5/2/24 meeting: Board of Directors committed $526.2 million for provider rate increases from 7/1/24–12/31/26.
6/4/26 meeting: Board of Directors committed $429.6 million for provider rate increases from 7/1/26–12/31/28.

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

November 2026

Personnel Summary (as of October 17, 2026, pay period)

	Filled	Open	Vacancy Administrative	Vacancy Medical	Vacancy % Combined
Staff	1,358.25	73.5	39	34.5	5.13%
Supervisor	84	4	2	2	4.55%
Manager	117	9	7	2	7.14%
Director	88	1	1	--	1.12%
Executive	20	2	1	1	9.09%
Total FTE Count	1,667.25	89.5	50	39.5	5.09%

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

Provider Network Data (as of October 22, 2027)

	Number of Providers
Primary Care Providers	1,266
Specialists	8,727
Pharmacies	501
Acute and Rehab Hospitals	46
Community Health Centers	73
Long-Term Care Facilities	257

Treatment Authorizations (as of August 31, 2026)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	43.72 hours
Prior Authorization – Urgent	72 hours	5.97 hours
Prior Authorization – Routine	5 days	1.14 days

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

Member Demographics (as of August 31, 2026)

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

Language Preference	
English	57%
Spanish	28%
Vietnamese	9%
Korean	2%
Other	1%
Farsi	1%
Chinese	1%
Arabic	<1%
Russian	<1%

Medi-Cal Aid Category	
Expansion	36%
Temporary Assistance for Needy Families	35%
Seniors	13%
Optional Targeted Low-Income Children	8%
People With Disabilities	6%
Other	1%
Long-Term Care	<1%

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Chief Financial Officer Report

Board of Directors Meeting

November 5, 2026

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.

Updates to the Board

- PACE Center (Irvine)
  - Remaining closing conditions are being finalized in preparation for escrow closing
  - Week of 11/2/26: Anticipate waiving remaining Governmental Approval contingencies to start the 30-day escrow closing period
  - Escrow is projected to close by 11/21/26
  - Site development will begin after the completion of escrow

Financial Highlights Notes: September 2026

- **Directed Payments:** $612.7 million of CY 2024 and CY 2025 Hospital Directed Payments were received and recognized in September 2026.

- **Prior Period Adjustments:** Final CY 2025 Medi-Cal capitation rates true-up from DHCS, offset by claim adjustments from prior periods, resulted in a net positive change of $8.8 million in Net Assets.

- **Investments:** Negative Investment Income reflects unrealized losses in market value driven by rising interest rates.

CalOptima Health

Financial Highlights
September 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
788,667	766,499	22,168	2.9%	Member Months	2,384,838	2,322,475	62,363	2.7%
1,029,431,604	368,664,341	660,767,263	179.2%	Revenues	1,793,156,336	1,115,592,105	677,564,231	60.7%
996,414,869	352,570,986	(643,843,883)	(182.6%)	Medical Expenses[1]	1,725,862,138	1,076,620,460	(649,241,678)	(60.3%)
22,127,773	25,303,644	3,175,871	12.6%	Administrative Expenses	65,826,781	76,047,803	10,221,022	13.4%
10,888,962	(9,210,289)	**20,099,251**	**218.2%**	**Operating Margin**	**1,467,417**	(37,076,158)	**38,543,575**	**104.0%**
				Non-Operating Income (Loss)				
(9,073,869)	8,333,330	(17,407,199)	(208.9%)	Net Investment Income/Expense	10,873,745	24,999,990	(14,126,245)	(56.5%)
(1,669,584)	-	(1,669,584)	(100.0%)	Grant Expense	(2,964,491)	-	(2,964,491)	(100.0%)
1,150,050	-	1,150,050	100.0%	Community Reinvestment	1,944,162	-	1,944,162	100.0%
1,186,145	(172,007)	1,358,152	789.6%	Other Income/Expense	879,106	(516,021)	1,395,127	270.4%
(8,407,258)	**8,161,323**	(16,568,581)	(203.0%)	**Total Non-Operating Income (Loss)**	**10,732,522**	**24,483,969**	(13,751,447)	(56.2%)
2,481,704	(1,048,966)	**3,530,670**	**336.6%**	**Change in Net Assets**	**12,199,939**	(12,592,189)	**24,792,128**	**196.9%**
96.8%	*95.6%*	*1.2%*		*Medical Loss Ratio*	*96.2%*	*96.5%*	(0.3%)	
2.1%	*6.9%*	*4.7%*		*Administrative Loss Ratio*	*3.7%*	*6.8%*	*3.1%*	
1.1%	(2.5%)	*3.6%*		*Operating Margin Ratio*	*0.1%*	(3.3%)	*3.4%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		

[1]Actual Medical Expenses include the Board-approved Provider Rate Increases

CalOptima Health

Enrollment Summary: September 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
103,063	100,607	2,456	2.4%	FAM	313,604	305,428	8,176	2.7%
229,203	225,850	3,353	1.5%	CHD	692,979	683,254	9,725	1.4%
277,972	265,860	12,112	4.6%	MCE	841,750	809,186	32,564	4.0%
3,007	3,177	(170)	(5.4%)	LTC	9,029	9,529	(500)	(5.2%)
147,038	142,305	4,733	3.3%	SPD	442,909	429,231	13,678	3.2%
8,665	8,516	149	1.7%	WCM	25,585	25,645	(60)	(0.2%)
768,948	**746,315**	**22,633**	**3.0%**	**Medi-Cal Total**	**2,325,856**	**2,262,274**	**63,582**	**2.8%**
19,126	**19,604**	(478)	(2.4%)	**OneCare**	**57,235**	**58,474**	(1,239)	(2.1%)
593	**580**	**13**	**2.2%**	**PACE**	**1,747**	**1,728**	**19**	**1.1%**
546	**581**	(35)	(6.0%)	**MSSP***	**1,671**	**1,737**	(66)	(3.8%)
788,667	**766,499**	**22,168**	**2.9%**	**CalOptima Health Total**	**2,384,838**	**2,322,475**	**62,363**	**2.7%**

*MSSP enrollment is included in Medi-Cal total

Balance Sheet: As of September 2026

ASSETS	
Current Assets	
Operating Cash	$261,510,007
Short-term Investments	1,858,175,339
Capitation Receivable	583,450,343
Receivables - Other	15,593,544
Prepaid Expenses	43,845,945
Total Current Assets	**2,762,575,178**
Capital Assets	
Capital Assets	227,338,470
Less: Accumulated Depreciation	(99,949,741)
Capital Assets, Net of Depreciation	**127,388,730**
Other Assets	
Net Pension Assets	4,069,081
Restricted Deposit	300,000
Board Designated Reserves	1,632,666,074
Statutory Designated Reserves	155,188,633
Total Other Assets	**1,792,223,788**
TOTAL ASSETS	**4,682,187,696**
Deferred Outflows	**30,923,013**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$4,713,110,709**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$221,073,714
Medical Claims Liability	357,833,429
Accrued Payroll Liabilities	30,015,794
Deferred Revenue	5,851,767
Due to State of California and CMS	703,762,892
Capitation and Withholds	137,476,993
Total Current Liabilities	**1,456,014,589**
Other Liabilities	
GASB 96 Subscription Liabilities	32,023,336
Community Reinvestment	64,997,176
Capital Lease Payable	183,953
Post Employment Health Benefits Liability	15,837,052
Net Pension Liabilities	0
Total Other Liabilities	**113,041,516**
TOTAL LIABILITIES	**1,569,056,106**
Deferred Inflows	**16,723,193**
Net Position	
Required TNE	151,766,779
Funds in Excess of TNE	2,975,564,631
TOTAL NET POSITION	**3,127,331,410**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**$4,713,110,709**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of September 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	815,335,413				
MetLife Tier One	817,330,660				
Board Designated Reserves	1,632,666,074	1,154,279,662	1,846,847,459	478,386,411	(214,181,386)
revenue) [1]	*3.54*	*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	77,666,204				
MetLife Tier Two	77,522,429				
Statutory Designated Reserves	155,188,633	151,766,779	166,943,457	3,421,854	(11,754,823)
Current Reserve Level (X min. TNE) [1]	*1.02*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

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Transition of Unsatisfactory Immigration Status (UIS) Members to Fee-for-Service (FFS) Medi-Cal

Board of Directors Meeting
November 5, 2026

Ladan Khamseh
Interim Chief Operating 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.

Transition Project Update

- CalOptima Health continues to collaborate with DHCS and our health networks to ensure members transition from CalOptima Health to Fee-for-Service (FFS) with minimal disruption
  - DHCS sent an impacted member list, which identified 125,828 members eligible with CalOptima Health through June 2026
  - After eligibility verification, 111,517 members remained, with 6,099 additional UIS members identified by CalOptima Health, for a total of **117,616 members**
  - DHCS has specific transition of care requirements through December 31, 2026, that managed care plans must support

Member Communication and Outreach

- Efforts are underway and will continue through the end of the year
  - Focused on educating members about the upcoming changes and providing assistance and support
  - Customer Service staff have been trained on how to assist all members transitioning to FFS
- Outreach is frequent and layered (multiple touchpoints, i.e., phone, letter, text, etc.)
  - September 30: CalOptima Health Case Management began outreach to Whole Child Model UIS members to educate and provide support in the transition to Orange County's California Children's Services (CCS) program

Member Communication and Outreach (Cont.)

- October 9: DHCS sent a text message to impacted members, and additional texts will follow in November and December
- October 23: CalOptima Health and its health networks began phone outreach to high-urgency members (identified by DHCS and CalOptima Health) to provide support
- October 23: CalOptima Health staff began outreach to more than 400 OneCare members affected
  - OneCare members must transition out of our Dual Eligible Special Needs Plan to FFS Medi-Cal and original Medicare or a Medicare Advantage plan
- October 28: CalOptima Health mailed a DHCS-approved notice to impacted members

Provider Communication and Outreach

- Launched communication and outreach across provider types to ensure coordination
  - Began effort in August by emailing the DHCS-approved communication to providers
  - Recently addressed the UIS topic at Health Network Forum, Community Clinics Forum, LTS/SNF Forum and Hospital CEO Consortium
- Sent a survey to more than 1,000 providers about the UIS transition and Medi-Cal FFS participation
  - Gathering responses about awareness, resources needed, etc.

Provider Communication and Outreach (Cont.)

- Met with Orange County CCS to address and discuss concerns regarding the transition of UIS Whole Child Model members
  - Next meeting is scheduled for November 19
- Planning targeted outreach and engagement with specialty providers who have a high volume of UIS members
- Supporting specialist participation in the transition to minimize care disruption

CalOptima Health

Provider Communication and Outreach (Cont.)

- Providing actionable information to various provider types
  - Community health centers: Received UIS member data (each provider's member list was sent individually) during the week of October 19; set biweekly meetings with the Coalition of Orange County Community Health Centers to address challenges and impact of H.R. 1 and UIS transition
  - Health networks: Received UIS member rosters, including risk status; setting up a weekly authorization data exchange

DHCS Resources

- Transition toolkit: Outreach materials, key messages and resources to help explain upcoming Medi-Cal changes and FFS transition
- Provider information: What providers need to know about the transition, provider actions, provider resources, delivery of services for behavioral health and PACE, and resources for members
- FAQ: List of questions and answers related to the transition for providers

CalOptima Health

DHCS Requirements

- CalOptima Health must submit member-level data to facilitate FFS transition
  - Completed
    - Summary of Provider Outreach (submitted 8/31/26)
    - Member Authorization Data (submitted 9/15/26 and weekly as of 10/15/26)
    - General Whole Child Model (WCM) Transition Plan (submitted 10/15/26)
  - Upcoming
    - Member contact information (11/6/26)
    - Non-emergency and non-medical transportation schedule and physician certification forms (12/7/26)
    - High-urgency member and provider outreach results (11/6 and 12/7/26)
    - Newly identified high-urgency members (11/6 & 12/7/26 and 1/4 & 1/29/27)

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CalOptima Health Board of Directors Meeting
November 5, 2026

Regular Joint Meeting of the Member Advisory and Provider Advisory Committees

Report to the Board

The Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) held a regular joint meeting on October 8, 2026.

The MAC and PAC reviewed and approved the 2027 joint meeting schedule.

Sara Lee, Sr. Attorney at Community Legal Aid SoCal and MAC's Member Advocate Representative, provided an overview of Legal Aid services and resources available to Orange County residents, with a focus on supporting individuals affected by the transition from Medi-Cal to Covered California. She discussed Legal Aid's health advocacy services, which help resolve coverage denials, terminations, eligibility disputes, billing issues, and other healthcare access concerns.

Ms. Lee highlighted common challenges members face during Medi-Cal and Covered California transitions, including coverage gaps, enrollment barriers, subsidy issues, and special enrollment requirements. She emphasized the importance of timely Medi-Cal renewals, reporting changes to the county, and understanding enrollment timelines to prevent coverage disruptions. She also described Legal Aid's case management, community resources, and advocacy efforts to address both individual cases and broader systemic issues. Ms. Lee answered several questions from MAC and PAC members.

Lucille Kowalski, Federal Programs & Benefits Specialist; Nelly Kim, Federal Programs & Benefits Specialist; and Crystal Chavez, Self-Determination Coordinator, all from the Regional Center of Orange County (RCOC), presented on the various waivers available from RCOC.

Ms. Kowalski provided an overview of the Home and Community-Based Services Developmental Disabilities (HCBS-DD) Waiver, explaining that it allows individuals with developmental disabilities to receive services and supports in their homes and communities rather than in institutional settings. She noted that the Waiver enables California to obtain federal Medicaid funding for services not traditionally covered by Medi-Cal and supports community-based services provided through Regional Centers.

Ms. Kowalski also reviewed Waiver eligibility requirements, including Regional Center enrollment, full-scope Medi-Cal eligibility, qualifying level-of-care needs, and use of Regional Center-funded services. Attendees were informed that individuals may enroll in only one Waiver program at a time and must complete the required enrollment documentation. She also explained that federal reimbursement through the Waiver helps fund Regional Center services and supports California's commitment to community-based services under the Lanterman Act. A subsequent presentation provided an overview of the Self-Determination Program and its relationship to the HCBS-DD Waiver.

Ms. Kim explained that children served by Regional Centers may qualify for Medi-Cal under the HCBS-DD Waiver even when their family's income exceeds standard Medi-Cal eligibility limits. She noted that although Medi-Cal eligibility is generally based on household income, the Waiver allows parental income to be disregarded in certain circumstances, enabling eligible children to qualify based on their own income and needs.

Ms. Kim emphasized that children must first be evaluated for regular Medi-Cal eligibility. The HCBS-DD Waiver is a secondary pathway available only when a child is ineligible due to family income but is eligible for Regional Center-funded Waiver services at home. The program is available to children ages 3 to 18 and, in some cases, to young adults ages 18 to 21 who remain dependent on their parents.

Ms. Kim also clarified that Regional Center enrollment alone does not automatically qualify a child for Medi-Cal through the Waiver. Families must meet specific eligibility requirements, and the Waiver is intended as a last-resort option for children who would not otherwise qualify for Medi-Cal coverage.

Ms. Chavez provided an overview of the Self-Determination Program (SDP), a voluntary HCBS Waiver program that provides individuals with developmental disabilities with greater choice and control over their services and supports.

Ms. Chavez explained that SDP allows eligible Regional Center participants living in community settings to direct how their service funds are used, choose their own providers, and develop individualized support tailored to their goals and needs. The program is guided by the principles of choice, independence, responsibility, and person-centered planning.

She noted that key program components include an individualized budget, a spending plan, support from a service coordinator, optional Independent Facilitators, and required Financial Management Services providers who manage payments and administrative requirements. Participants must complete a state-required orientation before enrolling.

Ms. Chavez emphasized that although SDP offers greater flexibility than the traditional Regional Center service model, participants are responsible for managing their budgets, ensuring that services align with their Individual Program Plan goals, and using available generic resources, such as health insurance and educational services, before using Regional Center funding.

Aulina Bradley, CalOptima Health Director of Health Education, provided an overview of CalOptima Health's member education strategy, emphasizing a member-centered approach informed by population health data, community engagement, provider partnerships, and advisory committee input. She explained how member needs assessments, surveys, focus groups, and community partnerships are used to identify barriers to care, inform outreach efforts, and support health equity initiatives.

The presentation highlighted preventive care and chronic disease management programs, including cancer screenings, diabetes management, prenatal and postpartum education, behavioral health initiatives, and at-home testing programs. These efforts are designed to reduce barriers to care, improve access, and support members in managing their health.

Ms. Bradley also discussed provider support initiatives, including provider education, training opportunities, quality improvement programs, network adequacy efforts, and tools to reduce administrative burden and close care gaps. Member incentive programs continue to drive participation in preventive care and wellness services.

She also discussed how program success is measured using quality metrics, outreach effectiveness, population health outcomes, and member satisfaction surveys, which continue to show high satisfaction with case management and disease management programs. She emphasized the important role of advisory committees in identifying barriers, providing feedback, and shaping culturally responsive strategies that improve health outcomes and advance health equity for CalOptima Health members.

Lena Perleman, CalOptima Health Director, Medicare Operations, provided an overview of the 2027 OneCare benefit package, noting that benefit planning begins well in advance of the open enrollment period and is guided by member feedback, provider input, and a focus on improving health outcomes while maintaining member stability. Ms. Perleman emphasized that OneCare Complete will continue to offer comprehensive healthcare coverage, including $0 copays for primary care, specialist visits, hospital services, and prescription medications.

She further shared that a key enhancement for 2027 is restoring $0 copays for both generic and brand-name prescription drugs, addressing members' concerns about medication affordability and supporting better medication adherence. She also highlighted home delivery options for prescription medications to further reduce barriers to care. Additional supplemental benefits will continue to support members' overall health and well-being, including dental, vision, hearing, transportation, fitness, companion care, technology support, and Flex Card benefits. The Flex Card allowance will increase slightly to $170 per quarter and can be used for eligible over-the-counter health products and, for qualifying members, for healthy food purchases.

The presentation also highlighted preventive care incentive programs that reward members for completing activities such as annual wellness visits. Ms. Perleman emphasized that OneCare's comprehensive benefit package, care coordination services, and member support resources remain key differentiators in the competitive Medicare Advantage market and are designed to improve access, engagement, and health outcomes.

Ladan Khamseh, CalOptima Health Interim Chief Operating Officer (COO), introduced herself and noted that she is serving in the role following the former COO's departure and will remain in the role until a new COO is hired. She noted her long history with CalOptima Health, having been with the organization since its inception, and expressed appreciation for the opportunity to meet and work with the MAC and PAC committee members again.

Ms. Khamseh also provided an update on the upcoming Covered California product launch, noting that enrollment activities have already begun ahead of the January 2027 implementation. Approximately 92 members have been transferred to CalOptima Health, and staff is working to ensure a smooth transition and continuity of services for new members. She thanked the attendees for their participation and ongoing commitment to serving members.

Richard Lopez, M.D., CalOptima Health Interim Chief Medical Officer, provided an overview of robotic-assisted surgery, highlighting benefits such as enhanced visualization, minimally invasive procedures, faster recovery, and reduced blood loss. Common applications include urology, gynecology, colorectal, thoracic, cardiovascular, and orthopedic surgeries.

Dr. Lopez noted that a survey of Orange County hospitals found that most respondents offer robotic surgery, with many maintaining dedicated operating room teams and ongoing training programs. Although robotic surgery entails significant equipment and maintenance costs, he added that Orange County hospitals are well positioned to provide members with access to advanced surgical technologies and state-of-the-art care.

Donovan Higbee, CalOptima Health Sr. Director of Government Affairs, provided an update on the upcoming Medi-Cal work requirements and the fee-for-service transition, both scheduled to take effect January 1, 2027. He noted that additional guidance from the California Department of Health Care Services remains pending, particularly regarding work requirement exemptions and documentation requirements.

Mr. Higbee also noted that funding has been allocated to support clinics and navigation programs during implementation and that CalOptima Health is developing a comprehensive member outreach and education strategy. He added that updates will continue to be shared as additional state guidance becomes available.

The next joint MAC/PAC meeting is scheduled for December 10, 2026. Board assignments for items the Board would like the MAC and PAC to provide feedback on are welcome, and the MAC and PAC appreciate the opportunity to update the Board on current activities.

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

October 1, 2026

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on October 1, 2026, at CalOptima Health, 505 City Parkway West, Orange, California, with a teleconference location at Providence Health & Services Office, 1801 Lind Avenue SW, Renton, Washington. The meeting was held in person and via Zoom webinar. The meeting recording is available on CalOptima Health's website. Chair Vicente Sarmiento called the meeting to order at 2:19 p.m., following a recognition presentation for CalOptima Health Chief Operating Officer, Yunkyung Kim. Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Quorum was declared present as follows:

Members Present: Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; Catherine Green; Veronica Kelley (non-voting); and Janet Nguyen

Director Brian Helleland participated remotely under traditional Brown Act rules from the teleconference location listed above. He confirmed that no individual 18 years of age or older was present in the room with him.

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; R.J. Cooper, Outside General Counsel, Kennaday Leavitt; Scott Schoeffel, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Veronica Carpenter, Chief Administrative Officer; Richard Lopez, M.D., FACS, Interim Chief Medical Officer; John Tanner, Chief Compliance Officer; Steve Eckberg, Chief Human Resources Officer; Kathleen Linder, Chief Information Officer; Michaell Silva Rose, DrPH, LCSW, Chief Health Equity Officer; Tina Knapp, Clerk of the Board; and Cheryl Simmons, Program Manager

Clerk of the Board Tina Knapp noted the following changes to the agenda:

- The effective date for Item 11 was corrected from October 1, 2026, to November 1, 2026;
- Item 9, Recommended Action number 2, was continued to December 3, 2026; and
- Item 20 was continued to November 5, 2026.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Chief Executive Officer Michael Hunn reported that CalOptima Health's Covered California provider directory went live and that the organization received its first inquiry through Covered California's Shop and Compare website. He recognized staff and the Board for supporting the launch of the new line of business.

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Mr. Hunn reported a four-star National Committee for Quality Assurance rating, a four-star Medicare Part D rating, and an expected three-and-one-half-star overall Medicare rating. He also reported that CalOptima Health met all applicable Healthcare Effectiveness Data and Information Set measures identified by the Department of Health Care Services (DHCS).

Mr. Hunn reviewed preparations for the January 1, 2027, transition of members with Unsatisfactory Immigration Status (UIS) from managed care to fee-for-service Medi-Cal. He described ongoing coordination with DHCS, County departments, health networks, hospitals, community clinics, medical associations, delegated groups, and community partners; planned continuity-of-care efforts; and member communications that will be issued after DHCS authorization. Directors Veronica Kelley and Isabel Becerra discussed impacts on the County safety net, behavioral health services, community clinics, specialists, and continuity of care. Staff will return in November with an update, including any identified resource needs.

Mr. Hunn also recognized community partners and staff who supported the Senior Health and Wellness event and invited Board members to upcoming community events.

PUBLIC COMMENTS

The Board received general public comments from Muriel Casamayor; Hamed Noorzay, Qazizada Multicultural Therapy Clinic; Nahla Kayali, Access California Services; Becky Nguyen and Dung Hua, Vital Access Care Foundation; Angie Rowe, Beyond Blindness; Virginia Arvizu-Sanchez, Sacred Path Indigenous Wellness Center; Maryam Sayyedi, OMID Institute; Loreta Ruiz, Latino Health Access; and Vattana Peong, The Cambodian Family.

Speakers addressed provider support, enhanced care management (ECM), community health worker services, culturally and linguistically responsive care, direct contracting opportunities for community-based organizations, reimbursement and delegated-network barriers, and support for the UIS fee-for-service transition.

Chair Vicente Sarmiento requested a future agenda discussion regarding ECM infrastructure and community health worker services. Mr. Hunn stated that staff would continue discussions with the speakers and return at the November Board meeting with information, considerations, and options. Staff also agreed to review issues involving access to Indian Health Service facilities and provide follow-up.

CONSENT CALENDAR

2. Meeting Minutes
   - A. Approve Minutes of the September 3, 2026, Regular Meeting of the CalOptima Health Board of Directors
   - B. Receive and File Minutes of the May 28, 2026, Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee
3. Approve Reappointment and Chair Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee
4. Approve Reappointments to the CalOptima Health Board of Directors' Investment Advisory Committee
5. Adopt Resolution No. 26-1001-01 Approving Updated CalOptima Health Human Resources Policies
6. Approve CalOptima Health Pharmacy Management Policies Related to Covered California

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7. Approve CalOptima Health Operations Policies Related to Covered California
8. Approve CalOptima Health Network Management Policies Related to Covered California
9. Approve Revisions to CalOptima Health's Community Relations Policies
10. Approve Modifications to Utilization Management Policies GG.1500 and GG.1508
11. Approve Modifications to Long Term Services and Supports Policy GG.1503
12. Approve CalOptima Health Clinical Operations Policies Related to Covered California
13. Receive and File – Monthly Financial, Compliance, and Government Affairs Reports
    A. August 2026 Financial Summary
    B. Compliance Report
    C. Government Affairs Reports
14. Receive and File – September & October Monthly Community Events and Sponsorship Reports
    A. CalOptima Health Community Outreach Summary
    B. Sponsorships & Community Participation Including Upcoming Events

Action: ***On motion of Director Catherine Green, seconded by Director Isabel Becerra, by roll call vote the Board of Directors:***
Approved the Consent Calendar Agenda Items 2 through 14, as amended.

AYES:	**Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; Catherine Green; Brian Helleland; and Janet Nguyen**
NOES:	**None**
ABSENT:	**None**
ABSTENTIONS:	**None**
RECUSALS:	**None**

DISCUSSION ITEMS

15. Accept, Receive, and File the Fiscal Year 2025-26 CalOptima Health Audited Financial Statements

Director Isabel Becerra reported that the Finance and Audit Committee (FAC) reviewed the audited financial statements and received a presentation from independent auditor Baker Tilly US, LLP at its meeting on September 17, 2026. She reported that the audit was clean and contained no findings.

Action: ***On motion of Vice Chair Maura Byron, seconded by Director Catherine Green, by roll call vote the Board of Directors:***
Accepted, received, and filed the Fiscal Year 2025-26 CalOptima Health consolidated audited financial statements as submitted by Baker Tilly US, LLP.

AYES:	**Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; Catherine Green; Brian Helleland; and Janet Nguyen**
NOES:	**None**
ABSENT:	**None**
ABSTENTIONS:	**None**
RECUSALS:	**None**

Back to Agenda

16. Approve the Revised CalOptima Health Medi-Cal Fiscal Year 2026-27 Operating Budget

Director Becerra introduced this item and indicated that the FAC also reviewed the revised Fiscal Year 2026-27 Operating Budget at its meeting on September 17, 2026. The FAC reviewed the recommended changes to the budget and the overall budget and found that it was prepared in a fiscally responsible manner. The FAC thanked Chief Financial Officer Nancy Huang and her team for their work in putting this together.

Ms. Huang presented revisions to the Operating Budget reflecting the UIS member transition and the delayed implementation of the Private Hospital Directed Payment program. She reported that the revisions apply to the Medi-Cal line of business for January through June 2027, reduce projected revenue and medical expenses, and result in revised projected operating income of $23.2 million on a consolidated basis. She stated that the revisions do not change planned provider rate increases, grants, capital investments, or community reinvestment commitments. Ms. Huang also discussed enrollment monitoring, administrative costs, staffing efficiencies, digital transformation, Covered California, and Program of All-Inclusive Care for the Elderly expansion.

Director Brian Helleland left the meeting at 3:38 p.m., before the vote on Item 16.

Action: ***On motion of Director Catherine Green, seconded by Director Isabel Becerra, by roll call vote the Board of Directors:***
Approved the Revised CalOptima Health Medi-Cal Fiscal Year 2026-27 Operating Budget and authorized expenditures and appropriated funds for the items in Revised Attachment A: Revised Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items.

AYES:	**Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; Catherine Green; and Janet Nguyen**
NOES:	**None**
ABSENT:	**Brian Helleland**
ABSTENTIONS:	**None**
RECUSALS:	**None**

17. Approve Amendment to Extend CalOptima Health's Coordination and Provision of Public Health Services Contract with the Orange County Health Care Agency

Chair Vicente Sarmiento and Director Janet Nguyen recused themselves from consideration of Item 17. Vice Chair Maura Byron presided over the item.

Action: ***On motion of Director Blair Contratto, seconded by Director Norma Garcia Guillen, by roll call vote the Board of Directors:***
Authorized the Chief Executive Officer, or designee, to execute an amendment to CalOptima Health's Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency to extend the contract term through December 31, 2031.

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AYES:	**Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; and Catherine Green**
NOES:	**None**
ABSENT:	**Brian Helleland**
ABSTENTIONS:	**None**
RECUSALS:	**Vicente Sarmiento, Chair, and Janet Nguyen**

Following the vote, Chair Sarmiento requested that legal counsel provide the Board with guidance regarding potential conflicts involving contracts with Orange County departments. Legal counsel agreed to circulate an opinion.

18. Approve Actions Related to CalOptima Health's Grantmaking Activities

Action: ***On motion of Director Catherine Green, seconded by Vice Chair Maura Byron, the Board of Directors:***
Approved the adoption of the Funding Priorities Framework for CalOptima Health's grantmaking activities.

AYES:	**Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; Catherine Green; and Janet Nguyen**
NOES:	**None**
ABSENT:	**Brian Helleland**
ABSTENTIONS:	**None**
RECUSALS:	**None**

19. Approve Actions Related to the Medi-Cal Eligibility Outreach Strategy

Victoria Torres, Community Health Initiative of Orange County, provided public comment in support of the Community Enrollers Academy and described its purpose of strengthening the accuracy, knowledge, and capacity of community enrollers.

Director Becerra expressed support for expanding participation by community-based organizations while continuing to include organizations with established enrollment expertise. Chief Administrative Officer Veronica Carpenter stated that staff is piloting the program and will share best practices with other health plans.

Action: ***On motion of Director Catherine Green, seconded by Vice Chair Maura Byron, the Board of Directors:***

1. ***Authorized CalOptima Health staff to proceed with development of a scope of work to be used in Notice of Funding Opportunity processes for both a Community Enrollers Academy and a Work and Community Engagement Requirement Navigation Service Program.***
2. ***Authorized the CalOptima Health Chief Executive Officer, or designee, to execute a contract with Community Health Initiative of Orange County for up to $100,000 for twelve months to facilitate the Community Enrollers Academy.***

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3. ***Allocated up to $6.1 million from the unallocated balance of $12.0 million previously appropriated for future Board-approved Medi-Cal Eligibility Outreach Strategy activities as follows:***
   a. ***Up to $100,000 for the contract with Community Health Initiative of Orange County;***
   b. ***Up to $2.0 million for the Community Enrollers Academy Notice of Funding Opportunity; and***
   c. ***Up to $4.0 million for the pilot Work and Community Engagement Requirement Navigation Service Program Notice of Funding Opportunity.***

AYES:	**Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; Catherine Green; and Janet Nguyen**
NOES:	**None**
ABSENT:	**Brian Helleland**
ABSTENTIONS:	**None**
RECUSALS:	**None**

Item 20, Approve New CalOptima Health Provider Contract Termination Policy EE.1142, was continued to the November 5, 2026, Board meeting.

CLOSED SESSION

The Board adjourned to Closed Session at 3:58 p.m. to discuss the following two items:

CS-1. CONFERENCE WITH REAL PROPERTY NEGOTIATORS – GOVERNMENT CODE SECTION 54956.8
Property: 17838 Gillette Avenue, Irvine, CA 92614
Agency Negotiator: CBRE
Negotiating Parties: CalOptima Health; MIM Intersect Owner, LLC
Under Negotiation: Price and terms

CS-2. PUBLIC EMPLOYEE APPOINTMENT – GOVERNMENT CODE SECTION 54957(b)(1)
General Counsel

The Board returned to Open Session at 4:59 p.m. and quorum was re-established.

ROLL CALL

Members Present: Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia-Guillen; and Catherine Green

(All Board members participated in person)

Members Absent: Brian Helleland; Janet Nguyen (left at 4:59 p.m.); and Veronica Kelley (non-voting) (left at 3:58 p.m.)

Chair Sarmiento stated that the Board met in Closed Session and asked R.J. Cooper, Outside General Counsel, Kennaday Leavitt, for the report on Closed Session Item 1. Mr. Cooper reported that, regarding

CS-1, the Board voted 7-0 to authorize the Chief Executive Officer, or designee, with assistance of legal counsel, where appropriate, for CalOptima Health's Benefit, waive any remaining contingencies under the Purchase and Sale Agreement between CalOptima Health, as Purchaser, and MIM Intersect Owner, LLC; as Seller, executed June 11, 2026, including the Governmental Approvals contingency; to determine whether the remaining conditions to Closing had been satisfied; to satisfy CalOptima Health's obligations under the Purchase and Sale Agreement; and, based on those determinations, to consummate the acquisition or terminate the Purchase and Sale Agreement.

AYES:	**Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; Catherine Green; and Janet Nguyen**
NOES:	**None**
ABSENT:	**Brian Helleland**
ABSTENTIONS:	**None**
RECUSALS:	**None**

Mr. Cooper further reported that there was no reportable action on CS-2.

DISCUSSION ITEMS CONTINUED

21. Authorize Initial Funding for Architectural, Engineering, and Construction-Related Services for Real Property Located at 17838 Gillette Avenue, Irvine, California

Ms. Huang explained that, upon Board approval of the initial allocation, staff would procure services in accordance with the Board-approved purchasing policy. Staff will provide regular project updates, including information regarding selected contractors, to support transparency and Board oversight.

Action: ***On motion of Vice Chair Maura Byron, seconded by Director Catherine Green, the Board of Directors:***
Authorized, upon completion of escrow, an initial funding allocation in an amount up to $16.91 million from undesignated reserves for the future Program of All-Inclusive Care for the Elderly (PACE) site development, including:
1. $300,000 for architectural, engineering and consultant services; and
2. $16,610,000 for tenant improvement and base building construction costs.

AYES:	**Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Norma Garcia Guillen; and Catherine Green**
NOES:	**None**
ABSENT:	**Brian Helleland and Janet Nguyen**
ABSTENTIONS:	**None**
RECUSALS:	**None**

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Sarmiento reminded Board members that annual compliance training assigned September 14, 2026, is due November 12, 2026.

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Vice Chair Byron thanked CalOptima Health for sponsoring Family Support Network's first annual Pathways Conference. Director Green reported on a well-attended senior event in Huntington Beach that CalOptima Health sponsored.

Board members again thanked Ms. Kim for her service and wished her well.

ADJOURNMENT

Hearing no further business, Chair Sarmiento adjourned the meeting at 5:06 p.m.

_____
Tina Knapp
Clerk of the Board

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

June 18, 2026

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on June 18, 2026, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar. The meeting recording is available on CalOptima Health's website.

Chair Jose Mayorga called the meeting to order at 3:21 p.m., and Director Cathy Green led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Jose Mayorga, M.D., Chair; Maura Byron; and Catherine Green, R.N. (All Committee members participated in person.)

Members Absent: None.

Others Present: Linda Lee, Executive Director, Quality Improvement; Kelly Giardina, Executive Director, Clinical Operations; Dr. Robin Hatam, Medical Director; Dr. Zeinab Dabbah, Deputy Chief Medical Officer; Dr. Kelly Bruno-Nelson, Executive Director, Cal AIM; Yunkyung Kim, Chief Operating Officer; Veronica Carpenter, Chief Administrative Officer; Heather Sedillo, Director, GARS; Ruby Nunez, Executive Assistant; Samantha Pellón, Vice President, Chapman Consulting; Gretchen Nye, Director, Chapman Consulting; and Lori Sato, Chair, Whole-Child Model Family Advisory Committee.

ADVISORY COMMITTEE UPDATES

1. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update

Monica Macias-Garcia, Director, CalOptima Health PACE, provided a brief update of the PACE Member Advisory Committee (PMAC) activities that included the recent Electronic Medical Record (EMR) transition and there continues to be confusion surrounding coordination of external appointments with participants. Ms. Macias- Garcia also described ongoing challenges with external providers who occasionally overlook PACE's role due to its smaller footprint in Orange County, requiring continued outreach and clarification. She also noted patients' enthusiasm for the potential expansion to a second location, expressing gratitude for current support and noting that the participants have expressed to her that the program feels increasingly full. Ms. Macias-Garcia stated that of the 582 participants enrolled in PACE they see about 145 participants per day.

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2. Whole-Child Model Family Advisory Committee (WCM FAC) Update

Lori Sato, Chair, WCM FAC, provided highlights from the May 19, 2026, meeting. She reported that the Committee received several program updates and discussed issues affecting WCM FAC families.

Chair Mayorga thanked Ms. Sato for her service and contributions to the WCM FAC.

PUBLIC COMMENTS

None.

CONSENT CALENDAR

3. Minutes
   a. Approve the Minutes of the March 19, 2026, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Byron, seconded by Director Green, the Committee approved the Consent Calendar as presented.***

AYES:	**Jose Mayorga, Chair; Maura Byron; and Catherine Green**
NOES:	**None**
ABSENT:	**None**
ABSTENTION:	**None**
RECUSALS:	**None**

Michael Hunn, Chief Executive Officer, expressed deep appreciation for Dr. Mayorga as he concluded his service on both the Quality Assurance Committee and the Board of Directors.

REPORTS/DISCUSSION ITEMS

4. Recommend that the Board of Directors Approve Modifications to CalOptima Health Policy: GG.1611

Linda Lee, Executive Director, Quality Improvement, provided a high-level overview of the modifications to policy GG.1611: Potential Quality Issues Review Process, explaining that the policy now includes expanded language to clarify that 805 and 805.01 reporting requirements for serious quality issues, aligning the procedure with Centers for Medicare & Medicaid Services (CMS), Department of Healthcare Services (DHCS), and state licensing board regulations. She also noted that the potential quality issue (PQI) case closure timeframe has been extended from 90 days to 120 days, consistent with industry standards and current Medi-Cal plan operations.

Ms. Lee further clarified that closing a Quality-of-Service case without physician review required two registered nurse reviewers, ensuring consistency and alignment with established Quality Improvement (QI) processes. Lastly, she reported that the policy's quality inbox has been updated for greater clarity, replacing individual contacts with a centralized communication point.

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Action: ***On motion of Director Green, seconded by Director Byron, the Committee recommended that the Board of Directors approve modifications to CalOptima Health Policy GG.1611: Potential Quality Issue Review Process in connection with CalOptima Health's regular review process and consistent with regulatory requirements.***

AYES:	**Jose Mayorga, Chair; Maura Byron; and Catherine Green**
NOES:	**None**
ABSENT:	**None**
ABSTENTION:	**None**
RECUSALS:	**None**

5. Recommend that the Board of Directors Approve Reallocation of Remaining Non-monetary Gift Cards

Ms. Lee explained that in November 2022 the Board approved physical Target gift cards for member vaccination incentives during the COVID-19 emergency, and later for the OneCare preventative and wellness services in November 2023. She noted that CalOptima Health has since transitioned OneCare rewards to flex benefit digital cards, leaving a remaining inventory of approximately 2,600 physical cards. She stated that the action before the Committee was to seek approval to repurpose the cards for the already Board-approved 2026 Member Health Rewards Program using them to support annual wellness visits, breast cancer screenings, and chronic disease-related services. Ms. Lee emphasized that the cards could not be used for any other purpose because they were originally allocated for specific member incentive programs and that this reuse would allow CalOptima Health to responsibly draw down the inventory across the current and upcoming year.

Action: ***On motion of Director Byron, seconded by Director Green, the Committee recommended that the Board of Directors:***

1. ***Approve the reallocation of the remaining non-monetary gift cards totaling $16,425 from the Medi-Cal COVID-19 Member Vaccination Incentive Program to the Calendar Year 2026 Medi-Cal Member Health Rewards Program.***
2. ***Approve the reallocation of the remaining non-monetary gift cards totaling $2,750 from the OneCare COVID-19 Member Vaccination Incentive Program and $65,600 from the OneCare Calendar Year 2024 Member Health Rewards Program to the Calendar Year 2026 OneCare Member Health Rewards Program.***

AYES:	**Jose Mayorga, Chair; Maura Byron; and Catherine Green**
NOES:	**None**
ABSENT:	**None**
ABSTENTION:	**None**
RECUSALS:	**None**

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INFORMATION ITEMS

6. Grant Management Activities and Updates

Kelly Bruno-Nelson, Executive Director, CalAIM, provided an update on grant management activities. She explained that CalOptima Health was actively managing 148 grants with 135 on track., 10 experiencing delays or adjustments, and none on the watch list. She provided a presentation that reviewed several actively monitored grants.

Dr. Bruno- Nelson explained that per Board direction, CalOptima Health commissioned Chapman Consulting to assess its grant-management program against peer health plans and health philanthropies. She then introduced consultants Samantha Pellón and Gretchen Nye to present their analysis.

The consultants provided a presentation that reported that CalOptima's framework was strong and broadly consistent with peers, noting the portfolio's complexity being grounded in articulated funding priorities, having competitive grant making, lifecycle documentation, structured evaluation and governance oversight. The presentation also outlined grant programs, emphasized CalOptima Health's conflict of interest policies applied throughout grant decisions and highlighted DHCS community reinvestment requirement All Plan Letter 25-004 as an opportunity to align grants with local health jurisdiction priorities, review of 12 internal documents throughout the organization and observation that a lean team administers approximately 14-15 notice of funding opportunities (NOFOs) annually, and concluded that CalOptima Health's foundation was strong and aligned with peers, while targeted process refinements could further improve consistency and reduce administrative burdens as the portfolio evolves.

Ms. Pellón further explained that following their analysis, Chapman Consulting identified five targeted opportunities to enhance clarity, consistency, and operational efficiency. She recommended formalizing enterprise-level funding priorities so staff can clearly determine which requests fall in or out of scope. They also advised refining governance and portfolio management by better pacing NOFO releases and aligning reporting cycles with Board schedules to reduce administrative burden. The third recommendation emphasized fully leveraging CalOptima Health's lifecycle templates and the new lifecycle software solution, noting that internal rigor exceeded what appears in external-facing materials such as NOFOs.

7. Quality Improvement Program Updates
   a. Quality Improvement Health Equity Transformation Program Quarterly Report
   b. Health Plan Accreditation Update

Ms. Lee provided an update on the quarter one activity of the Quality Improvement and Health Equity Committee (QIHEC). She noted that the QIHEC met monthly during the first quarter of 2026 and continued its oversight of quality performance, accreditation status, performance improvement projects, member experience metrics, access and availability, grievances and appeals, and coordination of care. She reviewed annual program documents, including the QIHEC Transformation Program, Population Health Management Strategy, cultural and linguistics services and evaluations of prior Pay-for Value programs.

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Ms. Lee highlighted newly approved policies such as those governing member requests for medical records. She also presented several significant quality findings. Ms. Lee further stated that CalOptima Health earned the National Committee for Quality Assurance (NCQA) Health Equity Accreditation in December 2025 and will remain accredited through December 2028. She noted that the plan remains on track for its next health plan survey.

Ms. Lee also reported that CalOptima Health established a monthly data sharing with County Behavioral Health partners resulting in major accuracy improvements, including a 66% increase antipsychotic medication adherence. representing a 28-percentage-point gain largely driven by closing data gaps. She added updates on medication adherence support outreach involving 13,000 pharmacies and 3,400 members.

Ms. Lee also provided an overview of the Quality Improvement Committee sub-committee reports that included credentialing actions, probation and sanction monitoring, network-adequacy closures for OneCare and ongoing Medi-Cal gap mitigation, noting that the Credentialing and Peer Review Committee (CPRC) reported three preventable provider conditions to DHCS. Ms. Lee further noted that the Member Experience Committee met in January 2026 and closed out the 2024 network adequacy validation virtual audit. For OneCare and Medi-Cal the sub-committee identified several gaps for access to care in several specialties and South Orange County. Lastly, Ms. Lee stated that the Utilization Management (UM) Committee revised four UM policies and 19 pharmacy policies. The benefit management committee reviewed and reapproved 39 codes while the Pharmacy and Therapeutics Committee reviewed 11 new drugs where nine were added to the OneCare formulary with prior authorization.

Carmen Katsarov, Executive Director, Behavioral Health, responded to inquiries regarding antipsychotic medications and explained that long-acting injectable antipsychotics are typically administered in a clinical setting and processed through the Medi-Cal pharmacy benefit.

c. Quality Improvement Strategies

Kelli Glynn, Director, Quality Initiatives, presented an update on the Quality Improvement strategy emphasizing a member first, data driven, and provider-enabled approach. She described a multimodal outreach approach that tailored messages to members that reported barriers like customizing breast cancer screening reminders based on concerns about pain or fear and follow-up with messages that speak directly to those specific barriers. Ms. Glynn also highlighted improvements in data completeness and timeliness supported by Cozeva Payer One Strategy integrations, and expanded on at-home testing programs. She also highlighted mobile mammography success. She also reported updates that included improvements on engaging "unengaged" members via optimized calling times and scheduling workflows.

d. Member Grievances and Appeals Report

Heather Sedillo, Director, Grievances, Appeals, and Resolution Services (GARS), provided an overview of the member grievances and appeals report for the first quarter.

8. Utilization Management & Clinical Operations Updates

Kelly Giardina, Executive Director, Clinical Operations and Dr. Robin Hatam, Medical Director, provided a presentation that reviewed UM timeliness, UM program performance, utilization outcomes and sub workgroup updates, health network clinical oversight, emergency department support, transitional care services, and new clinical initiatives.

9. Whole Child Model Age Out Transition-PCP Incentive Pilot

Ms. Giardina presented the three-year performance-based incentive pilot program designed to support members transitioning from pediatric to adult services at age 21. The pilot aims to reduce service disruption through warm handoffs, care coordination, and increased engagement from adult PCPs. Providers can earn incentive payments based on specific billing codes related to care coordination and transition activities. The initiative expects to improve member satisfaction while reducing unnecessary hospitalizations and emergency department use.

10. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Health Equity Committee Report
    b. Program of All-Inclusive Care for the Elderly Report

These items were received and filed.

COMMITTEE MEMBER COMMENTS

Committee members expressed gratitude for the positive updates shared during the meeting. Director Byron shared personal reflections on Chair Mayorga's mentorship and impact on her understanding of committee work. Chair Mayorga offered final remarks on his tenure, his commitment to community service, and his pride in the organization's legacy.

ADJOURNMENT

Hearing no further business, Chair Mayorga adjourned the meeting at 4:56 p.m.

Ruby Nunez
Executive Assistant

Approved on: 10/15/2026

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve the CalOptima Health Measurement Year 2027 Medi-Cal and OneCare Pay for Value Programs

Contacts

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Richard Lopez, M.D., Interim Chief Medical Officer, (657) 900-1483

Recommended Action

1. Approve CalOptima Health Measurement Year 2027 Medi-Cal Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
2. Approve CalOptima Health Measurement Year 2027 OneCare Delegated Health Network Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
3. Approve the Measurement Year 2027 CalOptima Health Community Network Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs effective January 1, 2027, through December 31, 2027.
4. Approve the Measurement Year 2027 Shared Risk Pool Quality Measures effective January 1, 2027, through December 31, 2027.

Background

CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health Networks (HNs), CalOptima Health Community Network (CHCN), and HN's primary care physicians (PCPs), are eligible to participate in the P4V Program.

The purpose of CalOptima Health's P4V Program is to:

1. Recognize and reward HNs and CHCN PCPs for demonstrating quality performance;
2. Drive improvement in quality outcomes and processes through monetary incentives and penalties;
3. Provide comparative performance information for members, providers, and the public on CalOptima Health's HN and CHCN PCP performance; and
4. Provide industry benchmarks and data-driven feedback to HNs and CHCN PCPs on their quality improvement efforts.

CalOptima Health staff have obtained feedback from HN and CHCN physician partners on recommendations to refine and improve the P4V Program to drive improvement and achieve quality goals. Based on this feedback, CalOptima Health has shifted from an annual, retrospective

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pay-for-performance model to a real-time, point-of-care incentive approach, enabling providers to earn incentives as care gaps are closed. This new model launched in July 2026 with OneCare CHCN, and is now expanding to Medi-Cal CHCN, positioning us for full implementation in the 2027 program year.

Discussion

Measurement Process

CalOptima Health staff calculates the quality rating score for each HN annually. For Measurement Year (MY) 2027, staff will use the Integrated Healthcare Association (IHA) methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), and Centers for Medicare & Medicaid Services (CMS) Star measure data.

Medi-Cal Delegated HN P4V Program

Staff recommends implementing the MY 2027 Delegated HN Medi-Cal P4V Program with the following program components:

1. Maintain IHA pay for performance methodology to assess performance.
    a. The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.
    b. The greater of either the attainment or improvement score will be used to calculate incentive payments.
    c. A total quality score will be calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum. Measures are weighted 1.0 for clinical measures and 1.5 for member experience measures.
        i. The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned. For example, a quality rating of 3.5 equates to 35% of the incentive allocation.

2. Utilize the MY 2027 Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures held to minimum performance level (MPL) for the HEDIS measurement set. Based on preliminary notice from DHCS, the MY 2027 Medi-Cal P4V Program will have a total of 20 quality measures. CalOptima Health's P4V Program will adopt the final MY 2027 MCAS MPL measure set upon availability by DHCS.

3. Continue to include CAHPS composites and overall ratings as member experience measures. Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

4. Continue to use the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks. For MY 2027, MY 2026 Medicaid percentiles will be used as benchmarks.

5. Maintain program funding methodology at 10% of professional capitation (risk adjusted base capitation only).

6. Implement corrective action for HNs that score below the 50th percentile, requiring the HN to submit an improvement plan for that measure to CalOptima Health.

7. Apply the DHCS quality withhold as follows:
    a. DHCS will maintain its quality withhold and incentive program for managed care plans. For calendar year 2027, the quality withhold percent will remain 1.0% of capitation payments from each Medi-Cal managed care plan. DHCS may apply a higher withhold percentage in future Medi-Cal managed care plan contracts.
    b. Based on the DHCS quality measures, CalOptima Health will be assessed for the amount of withhold payments that may be earned back. The unearned percentage will be applied in CalOptima Health's P4V calculation across all HNs. Staff recommends deducting the percent of unearned DHCS withhold from each HN's earned P4V Program payment.

8. Utilize unearned incentive dollars for CalOptima Health-led system-wide quality interventions such as member health reward programs, mobile or at-home health screenings, digital measure improvements, and other targeted initiatives. Upon availability of funding from unearned incentive dollars after use for CalOptima Health-led interventions, CalOptima Health will also issue quality grants to HNs that will be directed toward improving individual measures or groups of measures.

OneCare Delegated HN P4V Program

Staff recommend implementing the MY 2027 OneCare Delegated HN P4V Program with the following program components:

1. Adopt the IHA pay for performance methodology, as described in the Medi-Cal section above, to assess performance.
    - Performance will be calculated on a Star rating scale based on CMS Star ratings. Each measure can earn between 1 and 5 stars.
    - Measures are weighted 1.0 for process measures, 2.0 for member experience measures, and 3.0 for outcome measures.

2. Utilize select CMS Part C and D measures for the P4V measurement set. Selected measures are those that are directly aligned with HN responsibilities.

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3. Utilize CMS Star cut-points as benchmarks. For MY 2027, the 2029 Star Rating cut points will be used.

4. Calculate the total quality score based on the sum of points earned for each measure on a scale of 1 to 5 stars.

5. Use the total quality score to determine the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.

6. The percentage of OneCare incentive earned will be determined as follows:

OneCare P4V Performance	MY2027/ SY2029 Incentive Percent
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year; SY= Star rating display year

7. Maintain program funding at $20 per member per month (PMPM).

8. Implement corrective action for HNs that score below 3-Stars, requiring the HN to submit an improvement plan for that measure to CalOptima Health.

9. Utilize unearned incentive dollars for CalOptima Health-led system-wide quality interventions such as member health reward programs, mobile or at-home health screenings, digital measure improvements, and other targeted initiatives.

MY 2027 CHCN Medi-Cal and OneCare PCP P4V Programs

CalOptima Health has implemented a real-time, physician P4V Program model for CHCN PCPs, transitioning away from the prior annual, retrospective structure. Staff recommends continuing this

real-time model into MY 2027, supporting improved quality performance and enhanced provider engagement through timely, actionable insights.

Staff recommends continued use of a software vendor to deliver the PCP P4V Program. The physician incentive software allows CalOptima Health contracted providers to view and close quality care gaps and earn corresponding P4V Program incentive dollars. The physician incentive software:

1. Provides a single view of health-promoting behaviors and corresponding incentive values through a simple user interface that engages PCPs and office staff.

2. Supports real-time updates to care gap closure status upon the physician/office staff taking action.

3. Ensures timely and transparent incentive payments to providers, providing payments throughout the year versus annually.

Providers will have visibility to their member panel with care gaps, actions that can earn incentives, and their progress made toward earning incentives as actions are taken and care gaps are closed. Incentives will range from $5 to $50 depending on the action taken and care gap closed.

The OneCare PCP P4V Program will utilize a two-tier incentive structure, with gap-closure payments of either $25 or $50 per qualifying action, reflective of the smaller OneCare member population and corresponding gap volume:

- Tier 1: $25 per care gap closed for quality measures that have demonstrated stable performance and/or are lower in complexity.
- Tier 2: $50 per care gap closed for quality measures where performance has plateaued, and/or are outcome-based.

The Medi-Cal PCP P4V Program will utilize a structured, three-tier incentive structure:

- Tier 1: $5-$25 per care gap closed for quality measures that require a single administrative touchpoint or are low in complexity.
- Tier 2: $30-$45 per care gap closed for quality measures that require clinical coordination (*e.g.,* multiple office visits required and/or are time-bound).
- Tier 3: $50 per care gap closed for quality measures that require complex clinical management and/or are outcome-based.

The total incentive payout shall not exceed 10% of total capitation. Funding for this program will draw from unearned MY 2025 P4V Program funds.

MY 2027 Unearned Incentive Dollars

MY 2027 P4V funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health's failure to achieve the MPL – may be used for quality improvement initiatives. Upon availability of funding, HN grants will be available from unearned funds for Medi-Cal only.

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HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Total grant funds to an individual HN will not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS quality withholds. Grants may not be used to fund administrative staffing nor for capital investments but may be used for staff for direct implementation of quality initiatives.

Staff will provide oversight of grants pursuant to CalOptima Health Policy AA.1400: Grants Management and will return to the Board of Directors (Board) to provide updates on the status of these grants at future meetings.

CalOptima Health will utilize a portion of the unearned MY 2027 CHCN HN P4V Program funds for the MY 2027 CHCN PCP P4V programs. CalOptima Health will also use unearned MY2027 Delegated and CHCN HN Program funds for CalOptima Heath-led quality improvement initiatives such as member outreach and education, programs to close care gaps, and programs to close data gaps.

Unearned incentive funds will be used as described herein. Staff will finalize expenditures from the MY 2027 P4V programs by Quarter 4 of 2028 and report back to the Board.

Eligibility for Incentive Payments

Performance incentive payments to HNs are distributed upon final calculation and validation of each measurement rate. Performance incentive payments to CHCN PCPs are issued throughout the MY, with an additional payout after the MY closes to account for claims runout. To qualify for payments:

- A HN must be contracted with CalOptima Health during the entire measurement period (January 1, 2027, through December 31, 2027), the calculation period (January 1, 2027, through December 30, 2027), and at the time of disbursement of payment.
- Providers must be contracted as a PCP with CalOptima Health CHCN at the time of payment distribution and must have at least five (5) CalOptima Health members attributed at the TIN level for each line of business.
- HNs and PCPs must also be in good standing with CalOptima Health at the time of disbursement of payment. CalOptima Health considers a provider in good standing if they have a valid contract during service, measurement and payment periods, and are not subject to any sanctions, exclusions, or preclusions. This status is verified by the Audit and Oversight Department. HNs must distribute a minimum of 85% of their incentive payment to their contracted physicians.

Shared Risk Pool Quality Measurement

HNs under a shared risk arrangement are subject to meeting quality measurement requirements to receive payment from shared risk pool funds, as defined in CalOptima Policy FF.1010: Shared Risk Pool and Policy MA.3003: Medicare Shared Risk Pool.

For Medi-Cal, performance against the following selected P4V Program measures will determine eligibility for shared risk pool distribution:

1. Follow-Up after Emergency Department (ED) Visits for Mental Illness-30 Days.
2. Follow-Up After ED Visits for Substance Use-30 Days.
3. Prenatal and Postpartum Care: Postpartum Care (7-84 Days).
4. Follow-Up after ED Visits for Mental Illness-30 Days.

For OneCare, performance against the following selected P4V Program measures will determine eligibility for shared risk pool distribution:

1. Follow-Up After ED Visits for Substance Use-30 Days.
2. Plan All-Cause Readmissions (30-Days).
3. Transitions of Care (31-Days)
4. Follow-Up after ED Visit for People with Multiple High-Risk Chronic Conditions (7-Days)

To receive shared risk pool payments, HNs must achieve at least the 25th percentile across the four measures for Medi-Cal and four measures for OneCare, separately. Performance will be calculated by averaging the percentile achieved for each measure, with each measure equally weighted. Any HN that does not meet this requirement will forfeit their portion of shared risk pool funds for that product line. Staff currently forecast all HNs will meet the minimum performance percentile.

Fiscal Impact

Medi-Cal P4V Program

Staff estimates that the fiscal impact for the MY 2027 P4V Program will be no more than 10% of the professional capitation (base rate only) or approximately $58 million. As a subset of this amount, staff estimates that approximately $11 million will go toward CHCN PCPs. Staff will include estimated pool funding for the MY 2027 P4V Program initiatives and grant activities in the Fiscal Year (FY) 2027-28 Operating Budget.

OneCare P4V Program

Staff estimates that the fiscal impact for the MY 2027 OneCare P4V Program will be no more than $20 PMPM or approximately $4.7 million. As a subset of this amount, staff estimates that approximately $1 million will go toward CHCN PCPs. Staff will include estimated pool funding for the MY 2027 P4V Program initiatives and grant activities in the FY 2027-28 Operating Budget.

Rationale for Recommendation

CalOptima Health strives to continuously improve the quality of care and outcomes for all members. CalOptima Health is committed to demonstrating breakthrough improvement in quality measures, achieving high performing managed care plan status, and achieving a 5-Star rating status. To achieve optimal quality performance and more fully engage the physician network, CalOptima Health will continue to shift from a retrospective P4V model to a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions.

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Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee (October 15, 2026)

Attachments

1. CalOptima Health Measurement Year 2027 Pay for Value Programs
2. MY2027 Pay for Value Program Presentation

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Attachment 1

CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

MY 2027 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V program also includes incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health primary care providers (PCPs) are eligible to participate in the Medi-Cal P4V program.

MY 2027 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2027 MCAS measure set.

MY 2027 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness - 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse - 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status - Combination 10	Breast Cancer Screening
Developmental Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents - Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS - Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS - Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months - Six or More Well-Child Visits	CAHPS - Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months - Six or More Well-Child Visits	CAHPS - Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS - Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS - Getting Care Quickly: Adult and Child
	CAHPS - Coordination of Care: Adult and Child

- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points

- Scale of 1-10 points
- Points based on performance between 50th percentile and 95th percentile.
- $1 + \left(\frac{(MY2027\ Rate - 50th\ Percentile)}{((95th\ Percentile - 50th\ Percentile)/9)} \right)$

▪ Improvement Points
- Scale of 0-10 points
- Points reflect performance in the prior year compared to the current year.
- $\left(\frac{(MY2027\ Rate - MY2025\ Rate)}{((95th\ Percentile - MY2025\ Rate)/10)} \right)$

3. Prior year (MY2026) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
4. Measure weighting
   - HEDIS measures weighted 1.0
   - CAHPS measures weighted 1.5
5. A total quality score will be calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
6. The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned. For example, a quality rating of 3.5 equates to 35% of the incentive allocation.
7. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
8. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
9. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
10. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

Attachment 1

CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

MY 2027 OneCare P4V Program Components

Alignment with the CMS Star program and the following components- CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2027 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults - Medication Review
	Care for Older Adults - Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care - Eye Exam
	Comprehensive Diabetes Care - Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Depression Screening and Follow-Up for Adolescents and Adults
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 1-5 points
       - Points based on performance between 3-Star and 5-Star cut points.

- $1 + \left(\frac{(MY2027\ Rate - 3\ Star\ cut\ point)}{((5\ Star\ cut\ point - 3\ Star\ cut\ point)/4)} \right)$
- Improvement Points
  - Scale of 0-5 points
  - Points reflect performance in the prior year compared to the current year.
  - $\left(\frac{(MY2027\ Rate - MY2025\ Rate)}{((5\ Star\ cut\ point - MY2025\ Rate)/5)} \right)$

3. MY2027 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2028 in the 2029 Star Rating Technical Notes.
4. Measure weighting
   - HEDIS process measures weighted 1
   - CAHPS measures weighted 2
   - Outcome measures weighted 3
5. A total quality score will be calculated based on the sum of points earned for each measure on a scale of 1 to 5 stars.
6. The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.

OneCare P4V Performance	**MY2027 Incentive Percentage SY2029**
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

7. Apply a program funding methodology of $20 PMPM
8. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance
9. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

Attachment 1

CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

Primary Care Provider Pay for Value Program (P4V)

The CalOptima Health Community Network (CHCN) Primary Care Provider (PCP) P4V program incentives:

- Performance on select Healthcare Effectiveness Data and Information Set (HEDIS®) Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL), and
- Performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures.

Measures are developed from industry standards including HEDIS and Pharmacy Quality Alliance.

In 2026, CalOptima Health began the shift from an annual, retrospective pay-for-performance model to a real-time, point-of-care incentive approach, enabling CHCN providers to earn incentives as care gaps are closed. Under this new approach, CHCN providers can earn incentive payments throughout the measurement year as quality care gaps are closed, rather than waiting for year-end reconciliation. This transition is supported by the implementation of a physician incentive software platform, which delivers the PCP P4V Program and provides contracted CalOptima Health providers with a single, streamlined interface to identify, address, and close care gaps. Through this platform, providers can take real-time actions and immediately earn the corresponding P4V incentive dollars. The physician incentive software:

1. Provides a single view of health-promoting behaviors and corresponding incentive values through a simple user interface that engages PCPs and office staff.
2. Supports real-time updates to care gap closure status upon the physician/office staff taking action.
3. Ensures timely and transparent incentive payments to providers, providing payments throughout the year versus annually.

Providers will have visibility to their member panel with care gaps, actions that can earn incentives, and their progress made toward earning incentives as actions are taken and care gaps are closed. Incentives will range from $5 to $50 depending on the action taken and care gap closed. The OneCare Program will utilize a two-tier incentive structure, with gap-closure payments of either $25 or $50 per qualifying action.

- Tier 1: $25 per care gap closed for quality measures that have demonstrated stable performance and/or are lower in complexity.
- Tier 2: $50 per care gap closed for quality measures where performance has plateaued, and/or are outcome-based.

The Medi-Cal Program will utilize a structured three-tier model:

- Tier 1: $5-$25 per care gap closed for quality measures that require a single administrative touchpoint or are low in complexity.
- Tier 2: $30-$45 per care gap closed for quality measures that require clinical coordination (e.g. multiple office visits required and/or are time-bound).
- Tier 3: $50 per care gap closed for quality measures that require complex clinical management and/or are outcome-based.

Providers must meet all program eligibility criteria:

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CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

1. Must be contracted as a primary care physician (PCP) with CalOptima Health CHCN at the time of payment distribution.
2. Must be in good standing with CalOptima Health at the time of payment distribution.
3. Must have at least 5 CalOptima Health members attributed at the TIN level for each line of business.

The total incentive payout shall not exceed 10 percent of total capitation for CHCN. Full program details are outlined in the Pay for Value Program Manual for CalOptima Health Community Network.

MY 2027 Medi-Cal P4V Program Components

Include select measures held to a DHCS MPL or quality withhold in the MY2027 MCAS measure set.

Measure	Tier	Amount Per Gap Closed
Depression Screening for Adolescents and Adults	Tier 1	$10
Developmental Screening in the First Three Years of Life	Tier 1	$10
Topical Fluoride in Children	Tier 1	$10
Postpartum Depression Screening	Tier 1	$10
Prenatal Depression Screening	Tier 1	$10
Lead Screening in Children	Tier 1	$15
Breast Cancer Screening	Tier 1	$25
Cervical Cancer Screening	Tier 1	$25
Colorectal Cancer Screening	Tier 1	$25
Depression Follow-Up for Adolescents and Adults	Tier 2	$30
Child and Adolescent Well-Care Visits	Tier 2	$30
Prenatal and Postpartum Care: Postpartum Care	Tier 2	$30
Prenatal and Postpartum Care: Timeliness of Prenatal Care	Tier 2	$30
Postpartum Depression Follow Up	Tier 2	$30
Prenatal Depression Follow Up on Positive Screen	Tier 2	$30
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Two or More Well-Child Visits	Tier 2	$40
Childhood Immunization Status- Combination 10	Tier 2	$45
Immunizations for Adolescents- Combination 2	Tier 2	$45
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	Tier 2	$45
Follow-up After ED Visit for Mental Illness- 30 days*	Tier 3	$50
Follow-Up After ED Visit for Substance Abuse- 30 days*	Tier 3	$50
Controlling High Blood Pressure**	Tier 3	$50
Glycemic Status Assessment for Patients with Diabetes (≤9%)**	Tier 3	$50

***** Because members may qualify for a measure multiple times, incentives will only be paid for up to three (3) denominator eligible events per member. For example, if a member meets the measure criteria ten (10) times, incentives can be earned for no more than three (3).

Attachment 1

CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

** Incentive determination will be based on the member's last qualifying value or test completed within the measurement year.

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CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

MY 2027 OneCare P4V Program Components

Alignment with the CMS Star program through the use of Part C and Part D measures, along with corresponding measure weights and Star cut-point benchmarks, by utilizing a defined subset of CMS Star measures.

Measure	Amount Per Gap Closed
Care for Older Adults – Medication Review	$25
Care for Older Adults – Functional Status Assessment	$25
Osteoporosis Management in Women who had a Fracture	$25
Diabetes Care – Eye Exam	$25
Kidney Health Evaluation for Patients with Diabetes	$25
Statin Therapy for Patients with Cardiovascular Disease	$25
Transitions of Care: Medication Reconciliation	$25
Transitions of Care: Patient Engagement After Inpatient Discharge	$25
Depression Screening and Follow-Up for Adolescents and Adults	$25
Statin Use in Persons with Diabetes (SUPD)	$25
Breast Cancer Screening	$50
Colorectal Cancer Screening	$50
Diabetes Care – Blood Sugar Controlled**	$50
Controlling Blood Pressure**	$50
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions*	$50

* Because members may qualify for a measure multiple times, incentives will only be paid for up to three (3) denominator eligible events per member. For example, if a member meets the measure criteria ten (10) times, incentives can be earned for no more than three (3).

** Incentive determination will be based on the member's last qualifying value or test completed within the measurement year.

Attachment 1

CalOptima Health Measurement Year (MY) 2027
Pay for Value Programs

Shared Risk Pool Quality Measurement

Medi-Cal MY2027 Quality Measures

1. Follow-Up after ED Visits for Mental Illness-30 Days
2. Follow-Up After ED Visits for Substance Use- 30 days
3. Prenatal and Postpartum Care: Postpartum Care (7-84 days)

Medicare MY2027 Quality Measures

1. Follow-Up After ED Visits for Substance Use- 30 Days
2. Plan All-Cause Readmissions (30-Days)
3. Transitions of Care (31-Days)
4. Follow-Up after ED Visit for People with Multiple High-Risk Chronic Conditions (7-Days)

Performance Calculation

For each measure, the rate achieved will be compared to the prior year (MY2026) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles. An averaged performance will be calculated by averaging the percentiles of achievement for the three measures. A minimum of the 25th percentile in average is required to receive payment from the shared risk pool. Any HN that does not meet this requirement will forfeit their portion of shared risk pool funds.

Measurement Year (MY) 2027 Pay for Value Program

Special Quality Assurance Committee Meeting

October 15, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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

Background

- CalOptima Health has implemented the Pay for Value (P4V) Program to reward high-performing Health Networks.
- The MY2026 P4V program was approved in November 2025.
- The intent for MY2027 is to carry forward the same core program components, while introducing targeted enhancements for Primary Care Providers (PCPs).

MY2027 Health Network Pay for Value Program Components

MY2027 P4V Program Elements

- Measure Sets
  - Medi-Cal: Align with Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPL) and Quality Withhold measures
    - Utilize HEDIS and DHCS clinical measures
    - Utilize both Child and Adult CAHPS rates
  - OneCare: Align with Centers for Medicare & Medicaid (CMS) Star measures most impactable by Health Networks (HN)s
    - Utilize Part C HEDIS and CAHPS measures
    - Utilize Part D medication management measures

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MY2027 P4V Program Elements

- Measure Weights
  - Align with industry measure weights, where applicable
  - Medi-Cal
    - Clinical measures = 1.0
    - Member experience measures = 1.5
  - OneCare
    - Process measures = 1.0
    - Member experience measures = 2.0
    - Outcome measures = 3.0
- Data Collection Methodology
  - To promote adoption of electronic clinical data sets, utilize administrative data

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Performance Methodology and Benchmarks

- Adopt Integrated Healthcare Association (IHA) scoring methodology
  1. Performance points are calculated by comparing HN score to benchmarks, starting at the 50th percentile for Medi-Cal and 3-Stars for OneCare
  2. Performance points are also calculated by comparing a HN's prior year score to current score
- Use option 1 or 2, selecting option with higher number of points
- Medi-Cal
  - Based on NCQA National Medicaid Percentiles
- OneCare
  - Based on CMS Star cut points

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Medi-Cal P4V Incentive Percentages

- A total quality score is calculated based on the sum of points earned for each measure on a scale of 0 to 10, with 10 as the maximum.
- The total quality score determines the percentage of incentive pool earned with the total rating equating to the percentage of incentive allocation earned.
  - For example, a quality rating of 3.5 equates to 35% of the incentive allocation

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OneCare P4V Incentive Percentages

- A total quality score is calculated based on the sum of points earned for each measure on a scale of 1 to 5 stars

OneCare P4V Performance	MY2027 Incentive Percentage Earned Star Year 2029
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

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Health Network Corrective Action

- Corrective action: HN scoring below the 50th percentile on Medi-Cal or below 3.0 Stars on Medicare must submit a corrective action plan

Additional Health Network Penalties

- CalOptima Health will pass down any impact of the DHCS quality withhold program
  - For MY2027, the withhold is 1.0% of capitation
  - Any unearned withhold will be deducted from each HN's PV4 program payment

MY2027 Incentive Pool

- Medi-Cal:
  - Ten percent of professional capitation (base rate only)
  - Estimated at $50 million

- OneCare:
  - $20 pmpm
  - Estimated at $4.7 million

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Unearned Incentive Dollars

- CalOptima Health will implement system-wide quality interventions (e.g., member reward programs, mobile or at-home health screenings, and other targeted initiatives).
- When funding is available, CalOptima Health will issue quality grants to HNs using unearned dollars.
- Grants will be directed toward improving individual measures or groups of measures.
- Funds may support a range of quality improvement activities, including staffing dedicated to quality initiatives.
- HNs submit a plan, subject to semi-annual monitoring
  - Must meet implementation requirements to continue to access improvement funds.

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MY2027 Primary Care Provider P4V Program Components

Primary Care Provider P4V

- CalOptima Health will implement a P4V program for primary care providers (PCPs) contracted directly with the CalOptima Health Community Network (CHCN).
- In 2026, CalOptima Health shifted from an annual, retrospective pay-for-performance model to a real-time, point-of-care incentive approach, enabling providers to earn incentives as care gaps are closed.
- This new model launched in July 2026 with OneCare CHCN, and is now expanding to Medi-Cal CHCN, positioning us for full implementation in the 2027 program year.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

Primary Care Provider P4V (cont.)

- Features of the PCP P4V program include:
  - Ongoing, transparent payment schedule:
    - Instead of receiving incentive payments once a year, providers will now receive monthly payments throughout the year as care gaps are closed.
  - New software platform:
    - CalOptima Health will utilize a software platform called Cozeva to deliver the P4V program.
    - Through Cozeva, providers will have a single interface to view care gaps, take actions, and earn incentives.
    - Cozeva will support real-time updates and transparent incentive payments throughout the measurement year.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

Primary Care Provider P4V (cont.)

- Providers must meet all program eligibility criteria:
  - Must be contracted as a primary care physician (PCP) with CalOptima Health CHCN at the time of payment distribution.
  - Must be in good standing with CalOptima Health at the time of payment distribution.
  - Must have at least 5 CalOptima Health members attributed at the TIN level for each line of business.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

Primary Care Provider P4V: Medi-Cal

- Incentives range from $5 to $50 depending on the action taken and care gap closed.
- Tier 1 ($5-$25):
  - Single administrative touchpoint or low complexity
- Tier 2 ($30-$45):
  - Clinical coordination (e.g. multiple office visits required and/or time-bound)
- Tier 3 ($50):
  - Complex clinical management/outcomes-based

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

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Primary Care Provider P4V: OneCare

- Incentives range from $25 to $50 depending on the action taken and care gap closed.
- Tier 1: $25 per care gap closed for quality measures that have demonstrated stable performance and/or are lower in complexity.
- Tier 2: $50 per care gap closed for quality measures where performance has plateaued, and/or are outcome-based.

Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

MY2027 CHCN* PCP P4V Program: Medi-Cal Measures (Tier 1)

Measure	Incentive Amount Per Gap Closed
Topical Fluoride in Children	$10
Depression Screening for Adolescents and Adults	$10
Development Screening in the First Three Years of Life	$10
Postpartum Depression Screening	$10
Prenatal Depression Screening	$10
Lead Screening in Children	$15
Breast Cancer Screening	$25
Cervical Cancer Screening	$25
Colorectal Cancer Screening	$25

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

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MY2027 CHCN* PCP P4V Program: Medi-Cal Measures (Tier 2)

Measure	Incentive Amount Per Gap Closed
Prenatal and Postpartum Care: Postpartum Care	$30
Prenatal and Postpartum Care: Timeliness of Prenatal Care	$30
Child and Adolescent Well-Care Visits	$30
Depression Follow-Up for Adolescents and Adults	$30
Postpartum Depression Follow Up	$30
Prenatal Depression Follow Up on Positive Screen	$30
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Two or More Well-Child Visits	$40
Childhood Immunization Status- Combination 10	$45
Immunizations for Adolescents- Combination 2	$45
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	$45

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

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MY2027 CHCN* PCP P4V Program: Medi-Cal Measures (Tier 3)

Measure	Incentive Amount Per Gap Closed
Follow-up After ED Visit for Mental Illness- 30 days**	$50
Follow-Up After ED Visit for Substance Abuse- 30 days**	$50
Controlling High Blood Pressure***	$50
Glycemic Status Assessment for Patients with Diabetes (≤9%)***	$50

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed 10 percent of total capitation for CHCN.

**Because members may qualify for a measure multiple times, incentives will only be paid for up to three denominator-eligible events per member. For example, if a member meets the measure criteria ten times, incentives can be earned for no more than three.

***Incentive determinations will be based on the member's last qualifying value or test completed within the measurement year.

CalOptima Health

MY2027 CHCN* PCP P4V Program: OneCare Measures

Measure	Incentive Amount Per Gap Closed
Breast Cancer Screening	$50
Colorectal Cancer Screening	$50
Care for Older Adults – Medication Review	$25
Care for Older Adults – Functional Status Assessment	$25
Osteoporosis Management in Women who had a Fracture	$25
Diabetes Care – Eye Exam	$25
Diabetes Care – Blood Sugar Controlled**	$50
Kidney Health Evaluation for Patients with Diabetes	$25
Controlling Blood Pressure**	$50

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed the CHCN incentive allocation.

**Incentive determinations will be based on the member's last qualifying value or test completed within the measurement year.

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MY2027 CHCN* PCP P4V Program: OneCare Measures (cont.)

Measure	Incentive Amount Per Gap Closed
Transitions of Care: Medication Reconciliation	$25
Transitions of Care: Patient Engagement After Inpatient Discharge	$25
Follow-up after Emergency Department Visit for People with Multiple High-Risk Chronic Conditions**	$50
Statin Use in Persons with Diabetes	$25
Depression Screening and Follow-Up for Adolescents and Adults	$25

*Program focus is on CalOptima Health Community Network (CHCN) members. The total incentive payout shall not exceed the CHCN incentive allocation.

**Because members may qualify for a measure multiple times, incentives will only be paid for up to three denominator-eligible events per member. For example, if a member meets the measure criteria ten times, incentives can be earned for no more than three.

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Shared Risk Pool Quality Measurement

Medi-Cal Shared Risk Pool Quality

- HNs under shared risk arrangement must meet quality measurement requirements to receive shared risk pool payments
- An average performance of the 25th percentile across measures is required to earn shared risk pool payments
- For MY2027 the measures are:
  - Follow-Up after ED Visits for Mental Illness-30 Days
  - Follow-Up After ED Visits for Substance Use- 30 days
  - Prenatal and Postpartum Care: Postpartum Care (7-84 days)

CalOptima Health

Medicare Shared Risk Pool Quality

- HNs under shared risk arrangement must meet quality measurement requirements to receive shared risk pool payments
- An average performance of the 25th percentile across measures is required to earn shared risk pool payments
- For MY2027 the measures are:
  - Follow-Up After ED Visits for Substance Use- 30 Days
  - Plan All-Cause Readmissions (30-Days)
  - Transitions of Care (31-Days)
  - Follow-Up after ED Visit for People with Multiple High-Risk Chronic Conditions (7-Days)

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APPENDIX

MY2027 Medi-Cal Health Network P4V Measurement Set

Measure	Measure
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Developmental Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening

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MY2027 Medi-Cal Health Network P4V Measurement Set

Measure	Measure
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

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MY2027 OneCare Health Network P4V Measurement Set

Measure Category	Measure
Part C	Breast Cancer Screening
HEDIS	Colorectal Cancer Screening
	Care for Older Adults - Medication Review
	Care for Older Adults - Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Depression Screening and Follow-Up for Adolescents and Adults

MY2027 OneCare Health Network P4V Measurement Set

Measure Category	Measure
Part C	Care Coordination
Member Experience	Getting Care Quickly
	Getting Needed Care
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Approve the Measurement Year 2027 CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168
Richard Lopez, M.D., Interim Chief Medical Officer, (657) 900-1483

Recommended Action

Approve the Measurement Year 2027 Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program, effective January 1, 2027, through December 31, 2027.

Background

During the November 7, 2024, CalOptima Health Board of Directors (Board) meeting, the Board approved modifications to the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value (MH Provider P4V) Program measures to better align with providers' administrative capabilities. The MH Provider P4V Program measures previously approved and listed in the table below continue to align with established standards, including selected Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures, Department of Managed Health Care (DMHC) timely access requirements, and clinical industry best practices. The MH Provider P4V Program is a proprietary CalOptima Health program.

	Category	Program Measures	Measure Value %
1	Quality Process	Timely Follow-up After BH/SUD/ED* visit	2.0%
2	Quality Process	Timely Follow–up After Initial Visits	2.0%
3	Quality Process	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	2.0%
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics	1.0%
6	Care Effectiveness	Clinical Measurement of Care	1.0%
7	Care Experience	Care Experience (Member Satisfaction)	1.0%
		Total	**10%**

*Behavioral Health (BH)/Substance Use Disorder (SUD)/Emergency Department (ED)

Discussion

After completing a comprehensive review of the first two measurement periods (January 1–June 30, 2025, and July 1–December 31, 2025), CalOptima Health staff identified several key adjustments to improve program alignment, reduce provider burden, and enhance measurement relevance. As a result,

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staff recommends the following modifications for implementation in the measure year (MY) 2027 MH P4V Program:

- **Discontinue Quality Monitoring of Essential Labs and Diagnostics (Measure 5):** Collecting lab values in the CalOptima Health Provider Portal did not add value for HEDIS reporting because it does not capture the documentation required for audit and validation and creates a burden to providers to enter manually.
- **Modify Clinical Measurement of Care (Measure 6):** Add and require the Patient Health Questionnaire-9 (PHQ-9) assessment for ages 12 years old and above, to support the HEDIS measure for Depression Screening and Follow-Up (DSF).
- **Discontinue Care Experience (Member Satisfaction) (Measure 7):** The quarterly text-based CalOptima Health Member Experience survey resulted in extremely low response rates, leaving insufficient data to support incentive eligibility.

Measurement and Payout Periods
The earned incentive of up to 10% premium on adjudicated claims remains unchanged. CalOptima Health calculates provider rating scores semiannually, allowing providers to track performance through scorecards. Incentive payments are issued after final calculation and validation. To qualify, mental health providers must maintain an active contract with CalOptima Health throughout the measurement and payout periods and remain in good standing as determined by the Audit and Oversight Department. Based on performance, providers may earn up to a 10% premium on adjudicated claims in the prospective payment period. The tables below outline the recommended measures, measure values, measurement periods, and payout periods for the MY 2027 MH P4V Program.

	Category	Program Measures	Measure Value %
1	Quality Process	Timely Follow-up After BH/SUD ED visit	2.5%
2	Quality Process	Timely Follow–up After Initial Visits	2.5%
3	Quality Process	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	2.0%
5	Care Effectiveness	Clinical Measurement of Care	2.0%
		Total	**10%**

MY 2027 Measurement Period	MY 2027 Payout Period
January 1 - June 30, 2027	January 1 - June 30, 2028
July 1 - December 31, 2027	July 1 - December 31, 2028

Fiscal Impact

Staff estimates that the annual fiscal impact for each payout period for the MY 2027 MH P4V Program will be no more than 10% of the contractually paid claim amounts or approximately $6.1 million. The estimated payments for the proposed payout periods will be included in future operating budgets.

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Rationale for Recommendation

The MY 2027 MH P4V Program will continue to improve the quality of care for CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee (October 15, 2026)

Attachments

1. Previous Board Action dated May 2, 2024: Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program
2. Previous Board Action dated November 7, 2024: Approve Modifications to the CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program
3. Behavioral Health Integration Mental Health Providers Pay for Value Programs Presentation

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CalOptima Health Board Action Agenda Referral

Action To Be Taken May 2, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Action

1. Approve the CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program with measurement periods starting January 1, 2025, through December 31, 2026.

Background

CalOptima Health's existing Medi-Cal Pay-for-Value (P4V) Program has aligned and incentivized performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) measures included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. The OneCare P4V Program utilizes Centers for Medicare & Medicaid Services (CMS) Star HEDIS and CAHPS measures and focuses on the most significant improvement opportunity.

Discussion

The Behavioral Health Integration leadership recommends implementing the Mental Health (non-Applied Behavior Analysis (ABA)) Provider P4V Program for mental health providers contracted directly with CalOptima Health. CalOptima Health's members have established trusted relationships with their physicians and mental health providers, which can help drive quality measures and member care coordination. The program will use industry standard measures aligned with federal and state requirements and guidance (*e.g.,* DHCS MCAS, CMS Star measurement sets) and applicable Department of Managed Health Care standards. The following provides more detail on the components of the Mental Health (non-ABA) Provider P4V Program.

Quality Measures

The mental health (non-ABA) providers will be measured according to the following 10 quality measures. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure.

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
1	Follow-Up After ED Visit for Mental Illness—30 days	FUM	NCQA	2.0
2	Follow-Up After ED Visit for Substance Use—30 days	FUA	NCQA	2.0
3	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	.75

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
4	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	.75
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	SSD	NCQA	.75
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E C&M	NCQA	.75
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E Init	NCQA	.75
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	.75
9	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	.75
10	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	.75
Total				**10**

Program Methodology
The quality measures will be compared to the DHCS Minimum Performance Levels (MPL) at the 50th percentile and Medicare measures will be compared to the National Committee for Quality Assurance (NCQA) Medicare National Percentile Benchmarks. The performance compared to benchmarks will earn incentives based on to following:

Performance Benchmark	Percent of Incentive Earned per Measure
50th percentile	50%
75th percentile	75%
90th percentile	100%

Program Measurement Period and Payout
The incentive budget is allocated based on the percentage of paid claims. Providers will be able to earn up to 10% of the paid claims during each measurement period based on their performance against the quality measures:

	Measurement Period	Incentive Payment Timeframe*
Baseline	January – December 2024	NA
Year 1	January – December 2025	Quarter 4 2026
Year 2	January – December 2026	Quarter 4 2027

*Incentive Payment Timeframe will be affected by HEDIS reporting timeframes and claims lag

Measurement Process and Incentive Payments
To qualify for incentive payments, mental health (non-ABA) providers must be contracted with CalOptima Health during the entire measurement period, be currently contracted, and in good standing with CalOptima Health, as determined by the Audit and Oversight Department. CalOptima Health staff

will calculate the rating score for the mental health (non-ABA) providers. The provider's performance score will be derived from the most recently audited plan-level HEDIS results. Providers can monitor their performance and progress through scorecards distributed by CalOptima Health. The distribution of the performance incentive payment will be based on each measure's rate final calculation and validation.

Fiscal Impact

Staff estimates that the annual fiscal impact for each measurement year for the Mental Health (non-ABA) Provider P4V Program will be no more than 10% of the paid claims during each measurement period or approximately $3.1 million.

Management will include 100% of pool funding for the measurement year (MY) 2025 Mental Health (non-ABA) Provider P4V Program initiatives in the Fiscal Year 2024-25 Operating Budget. The estimated payout for MY 2026 will be included in future operating budgets.

Rationale for Recommendation

The Mental Health (non-ABA) Provider P4V Program will improve the quality of care for our CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *04/26/2024*
Authorized Signature **Date**

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168

Recommended Actions

Approve the modifications to the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program measures.

Background

On May 2, 2024, the Behavioral Health Integration leadership recommended implementing the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program (Program) for mental health providers contracted directly with CalOptima Health. The Board of Directors approved the Program for measurement periods starting January 1, 2025, through December 31, 2026, for mental health providers contracted directly with CalOptima Health. The initial intent of the Program was to use industry standards aligned with federal and state requirements and guidance (*e.g.*, Department of Health Care Services (DHCS), Managed Care Accountability Set (MCAS), Centers for Medicare and Medicaid Services (CMS) Star measurement sets).

Discussion

Initially, the mental health (non-ABA) providers were to be measured according to the 10 quality measures listed below:

#	Quality Measures
1	Follow-Up After ED Visit for Mental Illness—30 days
2	Follow-Up After ED Visit for Substance Use—30 days
3	Depression Screening and Follow-Up for Adolescents and Adults
4	Depression Remission or Response for Adolescents and Adults
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics
9	Antidepressant Medication Management: Acute Phase Treatment
10	Antidepressant Medication Management: Continuation Phase Treatment

During an internal reevaluation of the Program before the intended go-live of January 2025, CalOptima Health had to revise the Program measures to align to the unique providers' current capabilities related to providing supplemental data submissions to show evidence of how the measures have been met. The updated measures listed in the table below will continue to align with the combination of standards,

including some HEDIS quality measures, Department of Managed Health Care (DMHC) timely access standards, and clinical industry best practices. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure. This Program is a CalOptima Health proprietary designed program.

	Category	Program Measures
1	Quality Process	Timely Follow-up After BH/SUD ED visit
2	Quality Process	Follow–up After Initial Visits
3	Quality Process	Effective Ongoing Care
4	Capacity/Growth	Capacity/Panel Growth
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics
6	Care Effectiveness	Clinical Measurement of Care
7	Care Experience	Care Experience (Member satisfaction)

Substance Use Disorder (SUD) / Emergency Department (ED)

Program Methodology

The data collection will be captured by various methods such as claims/encounter data, provider attestation forms, and digital surveys. The measurement review will be performed semi-annually.

The providers will be able to earn up to a 10% additional payment on claims during the payout period by achieving any or all the Program elements in the measurement period. The payout to providers will follow prospective payment methodology.

Measurement Period	Payout Period
Jan – Jun 2025	Jan – Jun 2026
July – Dec 2025	Jul – Dec 2026
Jan – Jun 2026	Jan – Jun 2027
July – Dec 2026	Jul – Dec 2027

To be eligible for this Program, the behavioral health providers must maintain a contract with CalOptima Health throughout the measurement period, still be contracted with CalOptima health, and be in good standing, as determined by the Audit and Oversight Department. CalOptima Health will have sole discretion to modify measurements and targets to drive maximum quality performance and will provide regular reports to the CalOptima Health Quality Assurance Committee.

Fiscal Impact

Staff estimates that the annual fiscal impact for each payout period for the Program will be no more than 10% of the paid claims or approximately $4.2 million on an annual basis. The estimated payments for the proposed payout periods will be included beginning with the Fiscal Year 2025-26 and will also be incorporated in future operating budgets.

Rationale for Recommendation

The Program will improve the quality of care for CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action dated May 2, 2024, Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Action

1. Approve the CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program with measurement periods starting January 1, 2025, through December 31, 2026.

Background

CalOptima Health's existing Medi-Cal Pay-for-Value (P4V) Program has aligned and incentivized performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) measures included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. The OneCare P4V Program utilizes Centers for Medicare & Medicaid Services (CMS) Star HEDIS and CAHPS measures and focuses on the most significant improvement opportunity.

Discussion

The Behavioral Health Integration leadership recommends implementing the Mental Health (non-Applied Behavior Analysis (ABA)) Provider P4V Program for mental health providers contracted directly with CalOptima Health. CalOptima Health's members have established trusted relationships with their physicians and mental health providers, which can help drive quality measures and member care coordination. The program will use industry standard measures aligned with federal and state requirements and guidance (*e.g.,* DHCS MCAS, CMS Star measurement sets) and applicable Department of Managed Health Care standards. The following provides more detail on the components of the Mental Health (non-ABA) Provider P4V Program.

Quality Measures

The mental health (non-ABA) providers will be measured according to the following 10 quality measures. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure.

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
1	Follow-Up After ED Visit for Mental Illness—30 days	FUM	NCQA	2.0
2	Follow-Up After ED Visit for Substance Use—30 days	FUA	NCQA	2.0
3	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	.75

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#	Quality Measures	Measure Acronym	Measure Steward	Weight %
4	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	.75
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	SSD	NCQA	.75
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E C&M	NCQA	.75
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E Init	NCQA	.75
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	.75
9	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	.75
10	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	.75
Total				**10**

Program Methodology

The quality measures will be compared to the DHCS Minimum Performance Levels (MPL) at the 50th percentile and Medicare measures will be compared to the National Committee for Quality Assurance (NCQA) Medicare National Percentile Benchmarks. The performance compared to benchmarks will earn incentives based on to following:

Performance Benchmark	Percent of Incentive Earned per Measure
50th percentile	50%
75th percentile	75%
90th percentile	100%

Program Measurement Period and Payout

The incentive budget is allocated based on the percentage of paid claims. Providers will be able to earn up to 10% of the paid claims during each measurement period based on their performance against the quality measures:

	Measurement Period	Incentive Payment Timeframe*
Baseline	January – December 2024	NA
Year 1	January – December 2025	Quarter 4 2026
Year 2	January – December 2026	Quarter 4 2027

*Incentive Payment Timeframe will be affected by HEDIS reporting timeframes and claims lag

Measurement Process and Incentive Payments

To qualify for incentive payments, mental health (non-ABA) providers must be contracted with CalOptima Health during the entire measurement period, be currently contracted, and in good standing with CalOptima Health, as determined by the Audit and Oversight Department. CalOptima Health staff

will calculate the rating score for the mental health (non-ABA) providers. The provider's performance score will be derived from the most recently audited plan-level HEDIS results. Providers can monitor their performance and progress through scorecards distributed by CalOptima Health. The distribution of the performance incentive payment will be based on each measure's rate final calculation and validation.

Fiscal Impact

Staff estimates that the annual fiscal impact for each measurement year for the Mental Health (non-ABA) Provider P4V Program will be no more than 10% of the paid claims during each measurement period or approximately $3.1 million.

Management will include 100% of pool funding for the measurement year (MY) 2025 Mental Health (non-ABA) Provider P4V Program initiatives in the Fiscal Year 2024-25 Operating Budget. The estimated payout for MY 2026 will be included in future operating budgets.

Rationale for Recommendation

The Mental Health (non-ABA) Provider P4V Program will improve the quality of care for our CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *04/26/2024*
Authorized Signature **Date**

CalOptima Health

Behavioral Health Integration(BHI) Mental Health Providers Pay-for-Value (P4V) Programs

Quality Assurance Committee

October 15, 2026

Carmen Katsarov, Executive Director, Behavioral Health Integration

Our Mission

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

Our Vision

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

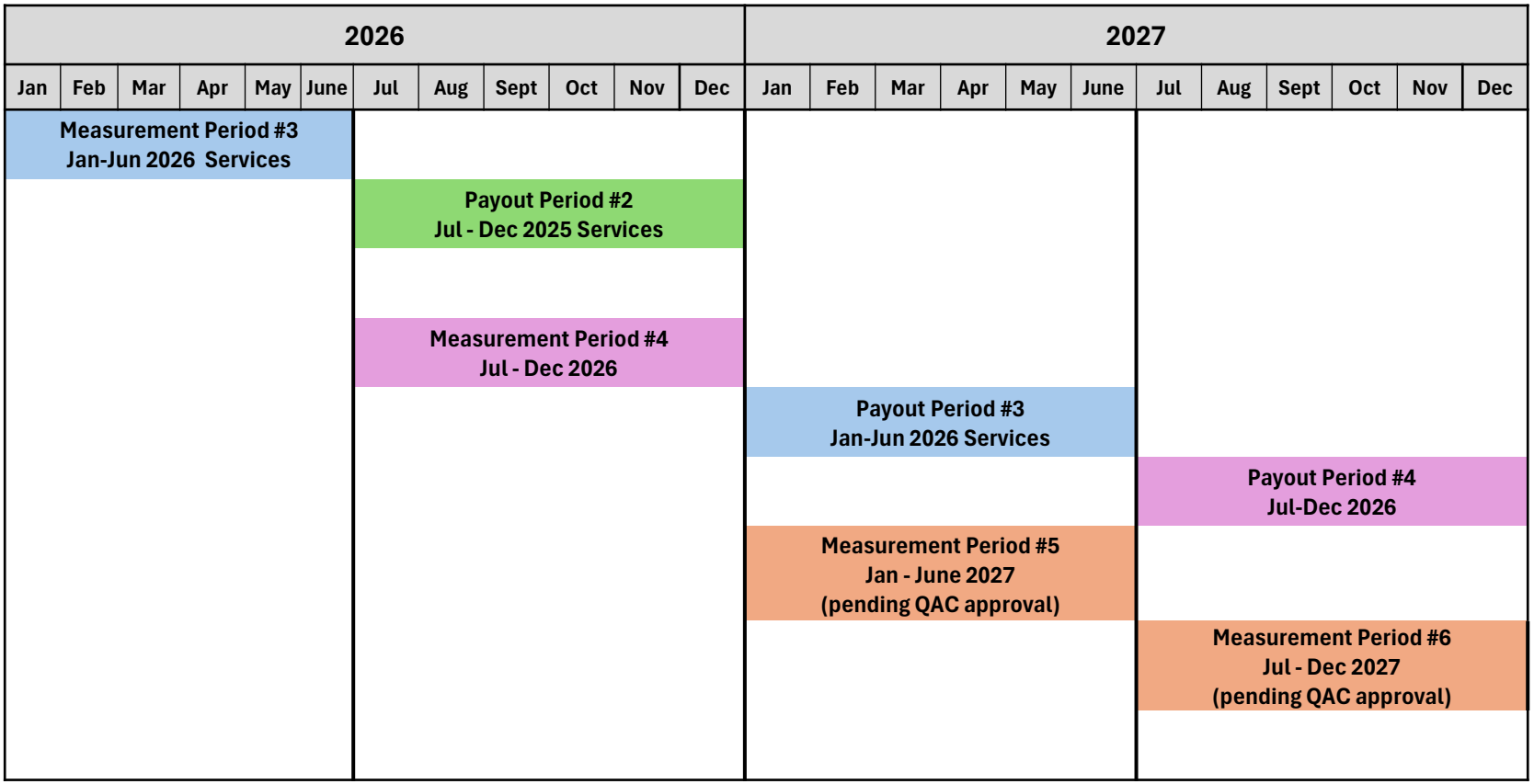
Background – MH BH P4V

- Board approved May 18, 2024 and November 7, 2024
- Program started January 1, 2025
- Providers can qualify for up to a 10% incentive applied to adjudicated paid claims during the payout period
- Program Framework
  - Measurement Period: **Every 6 months**
  - Data Source: Claims and encounter submissions, lab attestations, and mental health assessments
  - Review Frequency: Semi-annual performance review

Measurement Period	Review Period	Payout Period
Jan 1 – Jun 30, 2025	Jul 1 - Dec 31, 2025	Jan 1 – Jun 30, 2026
Jul 1 – Dec 31, 2025	Jan 1 – Jun 30, 2026	Jul 1 – Dec 31, 2026
Jan 1 – Jun 30, 2026	Jul 1 – Dec 31, 2026	Jan 1– Jun 30, 2027
Jul 1 – Dec 31, 2026	Jan 1 – June 30, 2027	Jul 1 – Dec 31, 2027

CalOptima Health

Measurement and Prospective Payout Periods



MH P4V Provider Performance

	Metric	MP: 1/1 – 6/30 2025	MP: 7/1 – 12/31 2025	MP: 1/1 - 6/30 2026*
1	Timely Follow-up after BH/SUD ED visit	33%	20%	14%
2	Timely Follow-up after initial visits	22%	10%	15%
3	Effective ongoing care	5%	2%	2%
4	Capacity / Panel Growth	77%	67%	57%
5	Quality monitoring of essential labs and diagnostics	N/A	0%	0%
6	Clinical Measurement of Care	N/A	0%	0%
7	Care Experience (Member Satisfaction) survey	0%	Discontinue	Discontinue

*Preliminary results as of 8/27/26

MH P4V: Program Modifications 2027 - 2028

- Modifications are based on internal reviews and discussions with the HEDIS team:
  - Discontinue Quality Monitoring of Essential Labs and Diagnostics (Metric 5): The manually entered lab values did not contain the supporting documentation necessary for HEDIS audit and validation thus it could not reliably contribute to HEDIS reporting.
  - Modify Clinical Measurement of Care (Metric 6): Add and require the Patient Health Questionnaire-9 (PHQ-9) assessment to support the HEDIS measure Depression Screening and Follow-Up (DSF).*
  - Discontinue Care Experience (Member Satisfaction) (Metric 7): The quarterly text-based CalOptima Health Member Experience survey resulted in extremely low response rates, leaving insufficient data to support incentive eligibility.

*Effective by July 1, 2027, depending on the availability of IT resources

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MH P4V Program: 2027 -2028

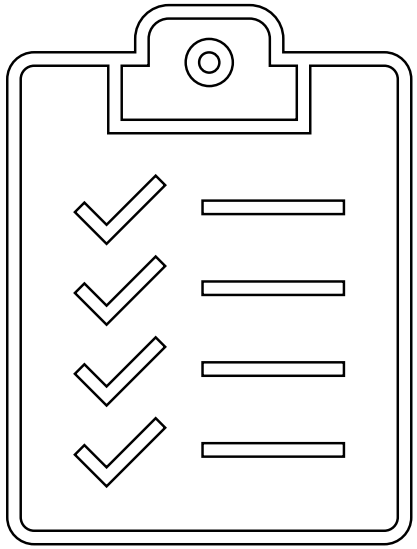
	Category	Program Metrics	Metric Value %
1	Quality Process	Timely Follow-up After BH/SUD ED visit	2.5%
2	Quality Process	Timely Follow–up After Initial Visits	2.5%
3	Quality Process	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	2.0%
5	Care Effectiveness	Clinical Measurement of Care	2.0%
		Total	10%

Measurement Period	Payout Period
January 1 - June 30, 2027	January 1 – June 30, 2028
July 1 – December 31, 2027	July 1 – December 31, 2028

CalOptima Health

MH P4V Program Next Steps

- QAC approve the program for measurement periods between January 1, 2027, and December 31, 2027
- Present as a Consent Item for the November 5, 2026, Board of Directors Meeting to continue the program
- Provide annual program updates to QAC for review and approval to maintain program continuation.



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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program

Contact

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

Approve the CalOptima Health Calendar Year 2027 Member Health Rewards Program for Medi-Cal and OneCare, effective January 1, 2027, through December 31, 2027.

Background

In calendar year (CY) 2026, CalOptima Health offered health rewards to eligible members through physical gift cards for Medi-Cal and flex cards for OneCare, to enhance member health and quality outcomes. CalOptima Health provided Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visits, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests, postpartum care, osteoporosis testing, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications. Reward fulfillment is executed through multiple validation pathways, such as claims-based confirmation, member self-attestation submitted via digital forms, and provider-verified documentation.

Discussion

Health rewards may motivate members to establish primary care relationships and receive recommended preventive care and screenings. Rewards may also encourage members to complete important tests, reinforce healthy behaviors, and positively impact member experience. CalOptima Health selects rewards based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

Staff recommends maintaining the CY 2026 incentive set for CY 2027, with no changes to covered measures or reward amounts. The program categories and incentives are listed in the table below.

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Proposed CY 2027 Member Incentives	
Medi-Cal	**OneCare**
Annual Wellness Visit - $50	Annual Wellness Visit - $50
Blood Lead Test 12 Months of Age - $25	Breast Cancer Screening - $25
Blood Lead Test 24 Months of Age - $25	Diabetes A1c Test - $25
Breast Cancer Screening - $25	Diabetes Eye Exam - $25
Cervical Cancer Screening - $25	Health Risk Assessment - $25
Colorectal Cancer Screening: Other Types* • Fecal occult blood test - $15 • Fecal immunochemical test - $15 • CT Colonography - $25 • Flexible sigmoidoscopy - $25	Colorectal Cancer Screening: Other Types* • Fecal occult blood test - $15 • Fecal immunochemical test - $15 • CT Colonography - $25 • Flexible sigmoidoscopy - $25
Colorectal Cancer Screening: Colonoscopy - $50	Colorectal Cancer Screening: Colonoscopy - $50
Diabetes A1c Test - $25	Osteoporosis Management - $25
Diabetes Eye Exam - $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications - $25	
Postpartum Checkup - $50	

*The reward amount will vary based on the type of colon cancer screening test completed.

Members will receive a health reward upon completing the qualifying service. At the time of budgeting, staff assumed a member participation rate of 15% for Medi-Cal and 20% for OneCare based on historical participation rates. For rewards tied to quality metrics using claims data, calculations include minimum performance thresholds and Centers for Medicare & Medicaid Services Star cut points to meet program and regulatory standards. Should the participation rates exceed these assumptions and budgeted amounts, staff will return to the CalOptima Health Board of Directors for additional funding requests at future meetings.

Staff recommends using unearned Measurement Year (MY) 2025 Pay-for-Value (P4V) Performance Program (the P4V Program) dollars to fund the Member Health Rewards Program. MY 2025 Medi-Cal P4V Program rewards have been preliminarily calculated. The total Medi-Cal P4V Program pool was $94 million (based on 10% of professional capitation for Fiscal Year 2025-26) with $34 million earned and $60 million unearned. The MY 2025 OneCare P4V Program pool will be calculated in November 2026, pending results from member satisfaction surveys. Staff expects OneCare performance similar to Medi-Cal with 30% earned and 70% unearned.

Fiscal Impact

Medi-Cal:
The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2027 Medi-Cal Member Health Rewards Program is $7.32 million. Staff anticipates that unearned funds from the MY 2025 Medi-Cal P4V Program will be sufficient to fund the program.

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OneCare:
The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2027 OneCare Member Health Rewards Program is $840,000. Staff anticipates that unearned funds from the MY 2025 OneCare P4V Program will be sufficient to fund the program.

Rationale for Recommendation

Maintaining the current program promotes preventive care, early identification, and chronic care management; strengthens primary care relationships; and supports quality performance objectives across Medi-Cal and OneCare populations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee (October 15, 2026)

Attachment

1. CY 2027 Member Health Rewards for Medi-Cal and OneCare Presentation

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Calendar Year 2027 Member Health Rewards for Medi-Cal and OneCare

Special Quality Assurance Committee Meeting

October 15, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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

Current 2026 Member Health Rewards Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- 11 Medi-Cal Health Rewards
- 8 OneCare Health Rewards
- Recommend continuing the program as currently designed for Calendar Year (CY) 2027

2027 Medi-Cal Program

Medi-Cal Health Reward	Reward Amount
Annual Wellness Visit	$50
Blood Lead Test 12 Months of Age	$25
Blood Lead Test 24 Months of Age	$25
Breast Cancer Screening	$25
Cervical Cancer Screening	$25
Colorectal Cancer Screening: Colonoscopy	$50
Colorectal Cancer Screening: Other Types • Fecal occult blood test - $15 • Fecal immunochemical test - $15 • CT Colonography - $25 • Flexible sigmoidoscopy - $25	$15-$25
Diabetes A1c Test	$25
Diabetes Eye Exam	$25
Diabetes Screening for People with Schizophrenia or Bipolar…*	$25
Postpartum Checkup	$50

*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

2027 OneCare Program

OneCare Health Reward	Reward Amount
Annual Wellness Visit	$50
Breast Cancer Screening	$25
Colorectal Cancer Screening: Colonoscopy	$50
Colorectal Cancer Screening: Other Types* • Fecal occult blood test - $15 • Fecal immunochemical test - $15 • CT Colonography - $25 • Flexible sigmoidoscopy - $25	$15-$25
Diabetes A1c Test	$25
Diabetes Eye Exam	$25
Health Risk Assessment	$25
Osteoporosis Management	$25

CalOptima Health

Summary of Fiscal Impact

- Estimated Cost at 15-20% Response Rate
  - Medi-Cal: approximately $7.32 million
  - OneCare: approximately $840,000

Program	CY 2026	CY 2027	Budget Difference
Medi-Cal	$6,300,000	$7,320,000	+ $1,020,000*
OneCare	$1,000,000	$840,000	- $160,000**

Passive health rewards were calculated based on Quality Compass Benchmarks or Star goals.

*The CY 2027 Medi-Cal budget increased due to larger denominators across multiple quality measures.

**The CY 2027 OneCare budget decreased due to the shift of the Annual Wellness Visit reward from passive claims-based processing to a member self-attestation model.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors'

Consent Calendar

10. Approve Actions Related to Implementation of a Quality Improvement Pilot Program

Contacts

Linda Lee, Executive Director, (657) 900-1069
Richard Lopez, MD, Chief Medical Officer (Interim), (657) 900-1483

Recommended Action

1. Authorize CalOptima Health staff to conduct a non-competitive, by-invitation-only, notice of funding opportunity related to the Quality Improvement Grant Pilot Program, administer grant agreements, and release award payments to the participating entities.
2. Authorize allocation of up to $500,000 from the CalOptima Health Community Care Network component of the Measurement Year 2025 Pay-for-Value Program for the Quality Improvement Grant Pilot Program.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

CalOptima Health annually implements a Quality Improvement Health Equity Transformation Program (QIHETP) pursuant to federal and state regulatory requirements. An important component of the QIHETP is the implementation of quality improvement projects to improve performance outcomes for areas that do not meet performance goals or are high priority focuses for quality outcomes. CalOptima Health has adopted an industry standard Plan-Do-Study-Act (PDSA) quality framework to ensure a rigorous implementation and evaluation process for quality activities.

To further encourage continuous quality improvement, the CalOptima Health Board of Directors (Board) renewed the Measurement Year (MY) 2025 Pay-for-Value (P4V) Program by approving the MY 2026 P4V Program at its December 4, 2025 meeting. Part of the P4V program includes a grant opportunity to contracted health networks. Under the MY 2026 P4V Program, there is no grant opportunity for providers participating in the CalOptima Health Community Care Network (CHCN).

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Discussion

CalOptima Health staff seeks to test the impact of quality improvement grants to CHCN providers to promote quality improvement under a quality improvement project framework. Under this grant opportunity for five community clinics, CalOptima Health will fund grants to implement the following quality activities to close clinical care gaps for preventive and chronic care services:

- Systematically identify and close care gaps across entire patient panels
- Proactively engage patients who have not yet established care or are overdue for preventive services
- Track and manage chronic disease populations between visits
- Coordinate timely follow-up after high-acuity events such as emergency department (ED) visits
- Monitor quality improvement pilot using PDSA framework

In line with CalOptima Health Policy AA.1400: Grants Management, all grant awards will include measurable objectives that document the progress and outcomes of the grant project. CalOptima Health staff will release a non-competitive, by-invitation-only NOFO to solicit the required documentation from participating entities no later than November 15, 2026 and will review proposals and be prepared to execute grant agreements for a January 1, 2027 start date. These activities will be funded for a 12-month period, anticipated to be January 1, 2027 through December 31, 2027. Each clinic will receive $100,000 to implement quality improvement activities described above.

The pilot program will include the following Federally Quality Health Centers (FQHCs) directly contracted with CHCN:

- Camino Health Center
- Friends of Family Health Center
- Laguna Beach Community Clinic
- Share Ourselves
- UCI Family Health Center

These clinics have formed a strategic alliance, Community Clinic Collaborative (C3), to promote quality improvement, share best practices, and conduct learning collaboration. This pilot is an opportunity to test the effectiveness of collaborative quality initiatives and joint learning.

Upon completion of the grant, CalOptima Health and participating clinics will evaluate impact of the pilot. Should the pilot yield meaningful improvement in quality outcomes staff will consider expansion of similar grants beyond the pilot period.

Staff will provide oversight of the grant pursuant to CalOptima Health Policy AA.1400: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

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Fiscal Impact

An allocation of up to $500,000 from the CHCN component of the MY 2025 P4V Program, approved by the Board on November 7, 2024, will fund the Pilot Program.

Rationale for Recommendation

By establishing defined quality improvement activities at FQHCs, staff anticipate marked improvement in care gap closure and quality outcomes. Implementation of standardized quality improvement projects will promote coordinating care and educating members thus addressing barriers to care.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee (October 15, 2026)

Attachment

1. Entities Covered by the Recommended Action

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Attachment to the November 5, 2026, Board of Directors Meeting – Agenda Item #10

CONTRACTED / IMPACTED ENTITIES COVERED BY THE RECOMMENDED ACTION

Name	Address	City	State	Zip Code
Camino Health Center	30300 Camino Capistrano 1300 Avenida Vista Hermosa, Suite 250 22481 Aspan St, Suite A	San Juan Capistrano San Clemente Lake Forest	CA CA CA	92675 92673 92630
Friends of Family Health Center	501 S Idaho St, Suite 100, 190, 250 13152 Newport Ave, Suite B	La Habra Tustin	CA CA	90631 92780
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Share Our Selves	1550 Superior Ave 27725 Santa Margarita Pkwy, Suite 101 1000 N Kramer Place, Suite 204 307 Placentia Ave, Suite 107 1014 N Broadway 1650 Adams Ave 2045 Meyer Place, Unit C	Costa Mesa Mission Viejo Anaheim Newport Beach Santa Ana Costa Mesa Costa Mesa	CA CA CA CA CA CA CA	92627 92691 92806 92663 92701 92626 92627
The Regents of the University of California, a California Constitutional Corporation, on behalf of the University of California Irvine Family Health Center	800 N Main St 2441 W La Palma Ave, Suite 100	Santa Ana Anaheim	CA CA	92701 92801

The list above only includes information that staff found through a search of publicly available information, and Directors should not solely rely on this list in determining whether a conflict of interest exists. Only a Director is aware of all their relevant interests under California law, and the California Fair Political Practices Commission ("**FPPC**") concluded that individual Directors are responsible for their own conflict determinations and advice (or lack of advice) from another party is not a defense for a violation. As such, this list is simply one tool that Directors may use in determining whether a conflict of interest exists. If a Director has a question about whether a specific interest is disqualifying, the Director should seek legal counsel to assist in making that determination.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve New CalOptima Health Policy: GG.1640 and Approve Modifications to CalOptima Health Policies: GG.1611, GG.1615, GG.1616, GG.1650, and GG.1651

Contacts

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Marsha Choo, Director, Quality Improvement, (714) 246-8670
Sharlee LeBleu, Director, Quality Improvement, (714) 246-8565

Recommended Action

Approve CalOptima Health Policy GG.1640: Health Network Pay for Value (P4V) Program and approve revisions to the following existing CalOptima Health policies:

- Policy GG.1611: Potential Quality Issue Review Process;
- Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues;
- Policy GG.1616: Fair Hearing Plan for Licentiates;
- Policy GG.1650: Credentialing and Recredentialing of Practitioners; and
- Policy GG.1651: Assessment and Reassessment of Organizational Providers.

Background

New Quality Improvement Policy and Procedure
CalOptima Health adopts new policies to ensure organizational practices remain aligned with evolving regulatory requirements, contractual obligations, and quality-of-care expectations across Medi-Cal, OneCare, Covered California, and administrative programs. Staff develops new policies when emerging standards, program changes, or operational needs require clear, consistent guidance to support compliance, promote accountability, and advance CalOptima Health's mission to deliver high-quality, equitable care to members.

Below is a summary of new CalOptima Health Policy GG.1640: Health Network Pay for Value (P4V) Program:

> CalOptima Health Policy GG.1640 establishes the structural foundation and operating requirements for CalOptima Health's Health Network P4V Program. It defines how the program is designed, measured, scored, and financially incentivized across Medi-Cal, OneCare, and Covered California product lines.

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The policy incorporates state, federal, and industry-standard quality frameworks. For Medi-Cal, it integrates the Managed Care Accountability Set (referred to as MCAS), Healthcare Effectiveness Data and Information Set (referred to as HEDIS®), Consumer Assessment of Healthcare Providers and Systems (referred to as CAHPS), and the Integrated Healthcare Association methodology. For OneCare, the P4V program aligns directly with the Centers for Medicare & Medicaid Services Star Rating System, using Star-aligned weights and performance tiers. The Covered California P4V Program uses Quality Transformation Initiative measures and benchmarks performance against National Committee for Quality Assurance national percentiles.

Across all programs, CalOptima Health Policy GG.1640 establishes a unified scoring model based on performance attainment and year-over-year improvement, with financial incentives tied to both. The policy also specifies required corrective actions for health networks that fall below established thresholds, ensuring ongoing accountability and remediation.

Collectively, these elements position the P4V Program as a standardized, regulatory-aligned framework that supports CalOptima Health's broader strategy to improve quality outcomes, elevate member experience, and advance health equity across the delivery system.

Modifications to Existing Quality Improvement Policies and Procedures
CalOptima Health also regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima Health operations. The recommended policy changes are made as part of CalOptima Health's regular review process and consistent with regulatory requirements.

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

CalOptima Health Policy GG.1611: Potential Quality Issue Review Process defines the process and procedure for intake, investigation, reviewing, leveling (outcome score), escalation, communication and closure of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department involving Providers and Health Networks servicing Members. Below are the proposed modifications to the policy.

Policy Section	**Proposed Changes**
II.F	Define investigative closure as the point at which a severity outcome score has been assigned, and administrative closure as the point at which all required follow-up actions have been completed.
II.L	Add language clarifying that Potential Quality Issue (PQI) review is not a delegated function.
III.A.4.	Add language clarifying that cases involving imminent danger to an individual's health must be immediately referred to the Chief Medical Officer (CMO), their physician designee, or the Credentialing and Peer Review Committee (CPRC) for

	potential summary suspension or restriction of a contracted provider's practice prerogatives.
III.D.2	Update the outcome score table to include clearer definitions and more descriptive explanations.
III.D.3	Add language stating that Medical Directors shall target case closure or submission of a case recommendation to CPRC within 30 days of case assignment, with an additional 30 days permitted when supplemental records are requested.
III.E.1.b	Add language stating that the Provider shall be notified that the PQI has escalated to CPRC review, and the notification shall include an offer for a written clarification/response or a call with the Medical Director assigned to the case.
III.F.4	Add language clarifying that corrective actions should be applied progressively
III.H	Clarify the frequency and scope of the reporting requirements.

CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues establishes CalOptima Health's process for initiating and managing corrective actions for Practitioners and Organizational Providers (OP) when quality-related concerns are identified. Below are the proposed modifications to this policy.

Policy Section	**Proposed Changes**
Name	Change the policy name to "Practitioner and Organizational Provider Corrective Action Plan of Quality Issues".
III.B.1.	Expand the list of possible corrective actions that can be implemented by CalOptima Health.
III.C.	Add a section outlining the formal Corrective Action Plan (CAP) process, including provider communication requirements, timelines, required CAP elements, criteria for approval, and steps taken when a CAP is not approved.

CalOptima Health Policy GG.1616: Fair Hearing Plan for Licentiates establishes CalOptima Health's fair hearing process for Licentiates when a hearing right is triggered by a reportable or otherwise hearing-eligible adverse action, and governs notice of action, hearing request requirements, hearing scheduling, pre-hearing exchange, hearing procedures, Judicial Review Committee (JRC) decision-making, and final action following the hearing. Below are the proposed modifications to this policy.

Policy Section	**Proposed Changes**
Name	Change the policy name to "Fair Hearing Plan for Licentiates".
All	Revise the policy to reference 'licentiate' rather than 'practitioner' throughout.
II.A.	Add the list of practitioner types included under licentiates.
II.B-C.	Define which adverse actions do and do not trigger fair hearing rights.

CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners defines the process by which CalOptima Health evaluates and determines whether practitioners meet the

qualifications for participation in CalOptima Health programs. Below are the proposed modifications to this policy.

Policy Section	**Proposed Changes**
II.B. (original)	Remove the section that permits the delegation of Medi-Cal screening and enrollment activities to delegates.
II.D.	Expand credentialing decision-making authority to the CMO/designee or CPRC and added a three-year credentialing approval period.
II.I.7.	Expand the practitioner types subject to credentialing and recredentialing.
II.K.3-6.	Strengthen minimum qualification review criteria to include fraud, waste, and abuse history, criminal history, liability claims history, and exclusion/sanction/debarment review.
II.T.	Clarify credentialing decision and notification timelines, including application expiration if no decision is made within six (6) months.
III.A.1-4.	Revise primary source verification and screening requirements, including additional verification elements and updated cross-references.
III.A.5. / III.B.5.	Add standardized documentation requirements for credentialing file verification.
III.C.	Expand practitioner rights related to review of information and status requests.
III.D.4-6.	Revise CPRC review and decision standards, including clean-file criteria, review process, and decision notification requirements.
III.F.	Clarify post-approval information-sharing and provider-directory update responsibilities.
III.H.	Expand required screening databases and ongoing monthly monitoring requirements.
Attachment A	Retire Attachment A, CalOptima Health Primary Source Verification Table.

CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, and eligibility to participate in CalOptima Health programs. Below are the proposed modifications to this policy.

Policy Section	**Proposed Changes**
II.D.	Clarify assessment/reassessment oversight and added a three-year initial credentialing period.
II.H.3-6.	Expand Medi-Cal screening criteria for providers without a state enrollment pathway.
III.A.2.c.	Expand acceptable business documentation to include a business tax certificate.
III.A.2.g.	Expand adverse-action screening across Medicare, Medi-Cal, and other federal/state health care programs.
III.B.1.f.	Apply the expanded adverse-action screening standard to Intermediate Care Facility for Developmentally Disabled assessments.

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III.D.3.a.	Revise clean-file criteria to add specific malpractice and National Practitioner Data Bank thresholds.
III.D.3.a.ii.	Revise CPRC's role from approval to review of clean files.
III.D.5.a.i-iii.	Expand approval outcomes, including time-limited approval and approval with conditions.
III.E.3.	Clarify that CalOptima Health does not currently perform Medi-Cal screening and enrollment directly.

Fiscal Impact

The recommended actions are operational in nature and have no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, rules, and accreditation standards, CalOptima Health staff recommends that the Board of Directors approve and adopt the new policy and procedure and revised policies and procedures. For existing CalOptima Health policies, the updated policy and procedure will supersede prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee (October 15, 2026)

Attachments

1. CalOptima Health Policy GG.1640: Health Network Pay for Value (P4V) Program
2. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
3. CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues
4. CalOptima Health Policy GG.1616: Fair Hearing Plan for Licentiates
5. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
6. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
7. Quality Policy Updates Presentation

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Policy:	GG.1640
Title:	**Health Network Pay for Value (P4V) Program**
Department:	Quality Analytics
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	TBD
Applicable to:	☐ Administrative ☒ Covered California ☒ Medi-Cal ☒ OneCare ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy defines requirements and processes for CalOptima Health's Health Network Pay for Value (P4V) Program to incentivize quality performance, improve health outcomes, and promote health equity through structured financial rewards and corrective actions.

II. POLICY

A. CalOptima Health shall implement P4V programs for Medi-Cal, OneCare, and Covered California Health Networks and Primary Care Providers (PCPs) for each measurement year (MY).

B. This program utilizes Integrated Healthcare Association (IHA) scoring methodology for Medi-Cal and OneCare, and benchmark comparison for Covered California.

C. Incentives are based on attainment and improvement scores, with corrective actions required for underperformance in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

D. Funding is allocated through Board-approved funds for each measurement year.

E. Unearned incentive dollars are redirected to quality improvement initiatives and grants in accordance with CalOptima Health Policy AA.1400: Grant Management.

III. PROCEDURE

A. Program Components:

1. Medi-Cal Pay for Value Program

   a. The Medi-Cal P4V Program utilizes the DHCS Managed Care Accountability Set (MCAS) measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures.

   b. Health Networks are scored using the Integrated Healthcare Association (IHA) methodology, which calculates both attainment and improvement points.

c. Attainment points range from one (1) to ten (10) based on performance between the 50th and 95th percentiles, while improvement points will range from zero (0) to ten (10) based on year-over-year progress.

d. The greater of the two scores will be used for each measure.

e. HEDIS measures are weighted at 1.0, and CAHPS measures will be weighted at 1.5.

f. Health Networks that score below the 50th percentile will be required to submit an improvement plan to CalOptima Health.

g. DHCS quality withhold penalties will be deducted from earned P4V payments.

2. OneCare Pay for Value Program

a. The OneCare P4V Program is aligned with the Centers for Medicare and Medicaid Services (CMS) Star Rating system and include select Part C and Part D measures.

b. Performance is assessed using a Star-based scale, with attainment and improvement points calculated according to CMS Star cut points.

c. HEDIS process measures are weighted at one (1), CAHPS member experience measures at two (2), and outcome measures at three (3).

d. Incentive payments will be based on overall Star performance, ranging from 0% for ratings below 3.0 Stars to 100% for ratings of 5.0 Stars.

e. Health Networks that score below 3.0 Stars will be required to submit an improvement plan.

3. Covered California Pay for Value Program

a. The Covered California P4V Program was developed from the Covered California Quality Transformation Initiative (QTI) measures.

b. Performance is assessed by comparing Health Network rates to National Committee for Quality Assurance (NCQA) Quality Compass National Exchange percentiles.

c. Incentive payments are awarded based on percentile achievement, with 100% of the incentive earned at the 75th percentile and 50% earned at the 50th percentile.

d. All measures will be weighted equally.

IV. ATTACHMENT(S)

A. CalOptima Health Measurement Year (MY) 2026 Pay for Value Programs Addendum

V. REFERENCE(S)

A. CalOptima Health Board Action Agenda Referral (November 13, 2025)
B. CalOptima Health Policy AA.1400: Grant Management
C. CalOptima Health Policy GG.1205: HEDIS Data Collection and Reporting
D. CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects
E. CalOptima Health Policy GG.1637: Assessing Member Experience
F. CalOptima Health Policy HH.2002: Sanctions
G. CalOptima Health Policy HH.2005: Corrective Action Plan

For 20261105 BOD Review Only

H. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements (Supersedes APL 19-017)
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-007: Enforcement Actions: Corrective Action Plans, Administrative and Monetary Sanctions (Supersedes APL 23-012)
J. Title 42 Code of Federal Regulations (CFR) §§ 438.310, 438.330, 438.358

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1640	Health Network Pay for Value (P4V) Program	Covered California Medi-Cal OneCare

For 20261105 BOD Review Only

IX. GLOSSARY

Term	Definition
Consumer Assessment of Healthcare Providers and Systems (CAHPS®:)	A standardized survey that measures members' experiences with health care services and providers.
Centers for Medicare and Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered California Quality Transformation Initiative (QTI)	A program that incentivizes quality improvement among Qualified Health Plans participating in Covered California.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Healthcare Effectiveness Data and Information Set (HEDIS®)	A widely used set of performance measures developed by NCQA to evaluate health care quality.
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.
Integrated Healthcare Association (IHA) Methodology	A standardized scoring approach used to calculate quality ratings based on attainment and improvement.
Minimum Performance Level (MPL)	The benchmark rate established by DHCS or CMS that health networks must meet or exceed for specific quality measures.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Pay for Value (P4V) Program	A performance-based incentive program that is designed to reward health networks and providers for achieving quality and equity goals.
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.
Star Ratings	A CMS quality rating system that evaluates health plans on a scale of 1 to 5 Stars based on clinical quality, member experience, and other measures.

For 20261105 BOD Review Only

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs Addendum

Program Component Appendix

MY 2026 Medi-Cal P4V Program Components

The Medi-Cal P4V Program incentivizes performance on all HEDIS® measures included in the DHCS Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V Program also includes incentives for CAHPS member satisfaction measures. Contracted HNs and PCPs are eligible to participate in the Medi-Cal P4V Program.

MY 2026 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2026 MCAS measure set.

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

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- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 1-10 points
       - Points based on performance between 50th percentile and 95th percentile.
       - $1 + \left(\frac{(MY2026\ Rate - 50th\ Percentile)}{((95th\ Percentile - 50th\ Percentile)/9)} \right)$
     - Improvement Points
       - Scale of 0-10 points
       - Points reflect performance in the prior year compared to the current year.
       - $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((95th\ Percentile - MY2025\ Rate)/10)} \right)$
3. Prior year (MY2025) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
4. Measure weighting
   - HEDIS measures weighted 1.0
   - CAHPS measures weighted 1.5
5. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
6. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
7. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
8. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

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CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs Addendum

OneCare P4V Program Components

The OneCare P4V Program focuses on select CMS Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Contracted HNs and PCPs are eligible to participate in the OneCare P4V Program.

MY 2026 OneCare P4V Program Components

Alignment with the CMS Star program and the following components: CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN

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- Attainment and Improvement score calculated for each measure. The better of the two scores is used.

- Scoring
  - Attainment Points
    - Scale of 1-5 points
    - Points based on performance between 3-Star and 5-Star cut points.
    - $1 + \left(\frac{(MY2026\ Rate - 3\ Star\ cut\ point)}{((5\ Star\ cut\ point - 3\ Star\ cut\ point)/4)} \right)$
  - Improvement Points
    - Scale of 0-5 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((5\ Star\ cut\ point - MY2025\ Rate)/5)} \right)$

3. MY2026 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2027 in the 2028 Star Rating Technical Notes.
4. Measure weighting
   - HEDIS process measures weighted 1
   - CAHPS measures weighted 2
   - Outcome measures weighted 3
5. Apply a program funding methodology of $20 PMPM
6. Available Incentive Pool: the OneCare incentive pool will be determined by each HN's Stars performance as described in the table below. Actual OneCareP4V Program incentives will be based on performance as described in this section.

OneCare P4V Performance	**MY2026 Incentive Percentage SY2028**
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

7. Performance incentive allocations will be distributed upon final calculation and validation of each HN's performance
8. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

Covered California P4V Program Components

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CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs Addendum

The Covered California P4V Program focuses on measures included in the Quality Transformation Initiative (QTI). Contracted HNs are eligible to participate in the Covered CA P4V Program.

MY 2027 Covered CA P4V Program Components

Alignment with the Covered CA Quality Transformation Initiative (QTI) and the following components

1. CalOptima Health will adopt the 2027 QTI measures for the MY2027 P4V Program.

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

2. Utilize an attainment scoring methodology where rates that meet designated benchmarks qualify for percentages of incentives per measure
3. MY2026 NCQA Quality Compass National Exchange percentiles used as benchmarks
4. Measures will be weighted equally
5. Establish program funding at ten percent (10%) of professional capitation (base rate only)
6. Covered CA P4V incentives will be based on performance compared to benchmarks as described below:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance

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Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	12/01/1999
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

This policy defines the process and procedure for intake, investigation, reviewing ~~and processing~~, leveling (outcome score), escalation, communication and closure of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department ~~for any Provider servicing Members~~involving Providers and Health Networks servicing Members. This policy also identifies when matters are referred to related policies governing corrective action, fair hearing, summary suspension or restriction, and external reporting.

II. POLICY

A. CalOptima Health departments, Health Networks (HNs) and Providers shall refer a PQI to the CalOptima Health QI Department for review and investigation~~.~~ when information suggests that a Member's Quality of Care (QOC), Quality of Service (QOS), patient safety, or related care process may have been compromised.

1. Quality-of-care Grievances are processed under applicable Grievance requirements and routed for PQI review when clinical quality review is indicated, in accordance with Policies: CC.1201: Member Grievance, HH.1102: Member Grievance, and MA.9002: Enrollee Grievance Process.

B. The QI Department shall serve as the single point of intake for PQI cases and shall log a PQI in CalOptima Health's care management system ~~and appropriately~~. Appropriately trained and qualified staff, including QI Nurses and CalOptima Health Medical Directors, shall review all PQIs. ~~Goals for the PQI review include improving Member outcomes, reducing errors, and/or enhancing efficiency.~~

C. The QI Department shall manage the PQI process through the following stages: intake and triage, information gathering, clinical and operational review, severity scoring, escalation when indicated, action implementation, provider notification, and case closure.

D. The QI Department shall use provider-facing communications at key process points, including when records or responses are requested, when a case is escalated for Medical Director or Credentialing and Peer Review Committee (CPRC) review, when corrective action is required, and when the case is closed.

E. The QI Department shall conduct ~~an~~timely investigation ~~on the~~of each PQI and obtain pertinent documentation needed to evaluate the issue. CalOptima Health shall meet the internal target for

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investigative closure within one hundred twenty (120) calendar days of receipt of the PQI, unless the case needs to be expedited as needed ~~to conduct the~~ for imminent member-safety risk or the case complexity, confidentiality limitations, external review needs, or related proceedings require additional time.

F. A case shall be considered:

1. Closed for investigation~~.~~ when a severity outcome score has been assigned;

2. Administratively closed when all required follow-up actions, including monitoring or corrective action verification, have been completed.

G. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health ~~Credentialing and Peer Review Committee (~~CPRC~~)~~ for evaluation and action~~, pursuant~~. Cases assigned Severity Outcome Score 3 shall be presented to CPRC. Other cases may be presented at the ~~CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP).~~Medical Director's discretion.

~~E. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank, and, as applicable, CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant Agency within fifteen (15) days after the effective date of an action of the CPRC, as further described in CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.~~

~~F. The QI Department shall track, trend, and analyze Provider and Health Network PQI data by issue, action(s), and level of severity monthly to identify emerging patterns.~~

~~a. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.~~

~~A. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary.~~

~~H. The QI Department shall prepare a summary report of all QI case activities monthly and submit the report for review to the CalOptima Health CPRC.~~

~~I. The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC) and to the Board of Directors Quality Assurance Committee (QAC) quarterly.~~

~~J.~~H. CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws. When a case is designated confidential because a Member chooses anonymity, CalOptima Health shall limit disclosures and blind Member-identifying information in provider-facing communications to the extent practicable and permitted by law.

I. The QI Department shall track, trend, and analyze PQI data by issue, action, and severity level monthly to identify emerging patterns, inform quality improvement activities, and support referral of repeated or significant issues for further review. Analysis and findings shall be reported to CPRC.

J. When the outcome of a PQI review leads to corrective action, summary suspension or restriction, fair hearing rights, or external reporting obligations, CalOptima Health shall follow the applicable requirements in Policies GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues, GG.1658: Summary Suspension or Restriction of Practitioner Participation in

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CalOptima Health's Network, GG.1616: Fair Hearing Plan for Licentiates, and GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

K. CalOptima Health maintains a formal, written Quality Improvement Health Equity Transformation Program (QIHETP) approved by CalOptima Health's Quality Assurance Committee (QAC) of the Board and overseen through the CPRC and clinical leadership. The PQI process is a component of this governance structure.

L. CalOptima Health does not delegate PQI review and retains direct responsibility for performance of these activities.

III. PROCEDURE

~~J. PQI cases given a severity level 3 shall send a letter per the following criteria as the recommendation of the Medical Director or CPRC:~~

~~1. The Providers contracted with CCN shall receive a letter outlining the findings of the investigation.~~

~~2. The Providers who are not contracted with CCN but are contracted with a CalOptima Health Network, shall receive a letter and a letter may be sent to their contracted Health Network requesting its review of the case and a request to provide a response to CPRC at the conclusion of their investigation.~~

~~3. For non-contracted Providers, a non-805 reportable letter may be submitted to the State Licensing Board requesting its review of the issue identified by CPRC.~~

~~II.I. PROCEDURE~~

A. Case Referral ~~and Identification~~Intake

1. In addition to PQI referrals ~~to CalOptima Health~~ made by Providers and Health Networks, a PQI may ~~also~~ be identified and referred to ~~the QI Department from multiple internal sources. Internal sources, include but are not limited to~~by CalOptima Health departments, ~~QIHEC~~committees and subcommittees, ~~and~~ Grievance activity, monitoring activity, and other QOC ~~-~~related activities ~~such as monitoring, analyzing, and improving processes to enhance Member outcomes, reduce errors, or improve efficiency.~~ .

~~2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review. This includes declined Grievances where the Member declines to file a Grievance, but a QOC issue is identified in the complaint.~~

~~3.~~ Supporting documentation ~~(e.g.,~~, including correspondence, Grievances, claims data, case management notes~~)~~, shall accompany the referral~~.~~

2. ~~Any entity~~ whenever available. The referring party shall indicate whether the Member requests anonymity. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.

~~a.~~ Upon receipt of a PQI referral, a PQI case shall ~~specify whether the Member chooses to remain anonymous.~~

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~~B. Process, Review, and Evaluation of PQI Cases~~

~~4.~~3. ~~PQI cases shall~~ be opened by the ~~CalOptima Health QI Department PQI team to review QOC issues, system issues, and/or administrative issues.~~QI Department. PQI cases shall be documented in CalOptima Health's care management system.

~~a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the care management system.~~

4. Cases identified as having imminent danger to the health of any individual shall be immediately referred to the CMO, their physician Designee, or CPRC to summarily suspend or restrict a contracted Provider's practice prerogatives if needed, in accordance with Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network.

B. Information Gathering, Provider Response, and Initial Review

1. The QI Nurse ~~shall~~ RN shall conduct an initial review of the PQI case and determine the additional information needed to conduct a full investigation.

~~1.~~2. The QI Department shall notify the Provider that a PQI has been opened, the issue related to the PQI and request pertinent medical records and ~~a~~, as applicable, a written response ~~to the PQI~~ from the ~~appropriate~~ Provider(s) and/or Health Network ~~that rendered medical services or were~~ involved ~~in~~ rendering medical service(s) ~~related to the PQI.~~ in the PQI. Requests shall specify the information sought, the requested submission date, the method of submission, and the CalOptima Health contact for procedural questions.

~~i. Medical records~~Unless otherwise specified due to urgency, confidentiality, or regulatory requirements, Providers and Health Networks shall be given a standard response ~~may or may not be able to be obtained~~timeframe established by department procedure, with extension requests considered for ~~confidential cases to maintain the Member's anonymity.~~

~~ii. If a Provider or Health Network fails~~***good cause. Failure to respond***~~:~~

~~2.~~3. ~~CalOptima Health's QI Department,~~ or submit requested information/documentation may result in ~~consultation with a CalOptima Health Medical Director, may take any~~review based on available information and ~~all reasonable actions it deems to be in the best interest of the Member~~may lead to further action, including ~~the issuance of~~ a corrective action ~~plan, pursuant to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers~~request, when appropriate.

~~3.~~4. ~~Data may also be collected from~~The QI Department may collect and review surveys, incident reports, claims data, grievances, and other ~~sources~~relevant internal or external information to assess QOC, QOS, and provider performance.

~~1. CalOptima Health's QI Department may deem it appropriate to deploy CalOptima Health's copying vendor to copy and obtain medical records.~~

5. ~~CalOptima Health's~~If Member anonymity limits the ability to obtain records or provider responses, the QI Department shall document those limitations and proceed using the information reasonably available.

~~4.~~6. The QI Department shall ~~analyze medical records and other data and will~~ target ~~case~~investigative closure within one hundred and twenty (120) calendar days of ~~receipt of the PQI. The case will be considered closed when it is~~

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~~given an outcome score~~PQI receipt. PQIs that are declined grievances shall receive preliminary Medical Director review within thirty (30) calendar days after the PQI is opened.

C. Nurse Review

1. The QI Nurse RN shall conduct a primary review of all PQI cases.

2. QI Nurses may close cases when ~~the following :~~

~~a.~~ The case is determined~~:~~

a. ~~The case is deemed~~ to be service-related only; and/or

b. No QOC or ~~Quality of Service (~~QOS~~)~~ issue is identified.

~~b. Declined Grievances shall be preliminarily reviewed by a CalOptima Health Medical Director within thirty (30) days of when the PQI is opened.~~

~~2.~~3. If ~~the~~a QI Nurse RN does not identify a QOC issue, ~~the case will be reviewed by~~ a second QI Nurse RN~~, and if~~ shall review the case. If the second QI Nurse RN concurs, the case ~~will~~may be ~~given an outcome score, designated~~scored, and closed with the ~~Action~~action of "No Further Action Required" and/or "Track and Trend~~" and the case will be closed.~~."

~~3.~~4. If the QI Nurse identifies a QOC issue, the case shall be referred to ~~and reviewed by the~~a CalOptima Health Medical Director~~, who must address~~ for review. The Medical Director shall assess service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services meet professionally recognized standards of practice. ~~Based upon the outcome of the review, the reviewer shall assign an outcome score that reflects the severity of the issue and determine if any further action will be taken. The case may be closed by the CalOptima Health Medical Director or be presented to CalOptima Health CPRC for further review and consideration(s).~~

~~a. Cases assigned severity Outcome Score 3 will be presented to CPRC for consideration and recommendation of action.~~

D. ~~Other cases may be presented to CPRC upon~~ Medical Director Review and Severity Scoring

1. The Medical Director shall conduct a secondary review of all QOC cases. The Medical Director shall assign an outcome score that reflects the severity of the issue and determine whether further corrective action is warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.

~~1.~~2. CalOptima Health ~~Medical Director's discretion.~~shall use the following outcome categories:

Outcome	Definition	Description ~~of Outcome Score~~
0	**No Impact / No Risk:** Care appears appropriate. No Quality-of-Care or Quality-of-Service issue identified.	• No provider error or lapse in clinical judgment. • Member received appropriate care without delay. • No documentation inaccuracies. • No follow-up action required beyond

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Outcome	Definition	Description ~~of Outcome Score~~
1	~~Mild clinical judgment~~**Low Impact / Minimal Risk:** Minor opportunity for improvement. Potential for or ~~operational issue with or without an~~actual, minor adverse outcome~~.~~ ~~to member~~	• Slight deviation from best practice or documentation expectations. • Isolated, non-recurrent provider behavior. • No harm or care disruption. • Corrected at provider or supervisor level.
2	**Moderate** ~~clinical judgment~~**Impact / Moderate Risk:** Moderate opportunity for improvement. Care deemed below standard or ~~operational issue with~~care, or ~~without an~~potential for or actual moderate adverse outcome~~.~~ ~~to member~~	• Moderate deviation from clinical guidelines or evidence-based practice. • Recurring provider documentation errors. • Member experienced a minor delay in care or care coordination. • Requires targeted provider feedback, re-training, or corrective action.
3	**High Impact / Significant Risk:** Significant opportunity for improvement. Care deemed below standard of care, or potential for or actual significant adverse outcome to Member.	• ~~Severe~~Major deviation from clinical ~~judgment~~practice guidelines or ~~operational issue with~~standards of care. • Member experienced care disruption or ~~without an~~temporary adverse outcome. • Provider error impacted diagnostic accuracy or care timeliness. • Requires immediate escalation and ~~to member~~
S0:	**Service Only / Unverified:** Service-related issue, unable to verify.	• No confirmable deviation in provider service or interaction. • Member dissatisfaction is noted, but objective evidence is absent. • No demonstrated impact on care, safety, or required services.
S1	**Service Only Verified:** Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.	• Service lapse confirmed (communication, respect, timeliness, professionalism). • No clinical impact or harm. • May affect member satisfaction or experience.

3. The Medical Director shall target a case investigative closure or case recommendation to CPRC within 30 days of the PQI case assignment. An additional 30 days is allotted if additional records or documentation is requested by the Medical Director.

4. The case may be closed for investigation by the CalOptima Health Medical Director or be referred and presented to CalOptima Health CPRC for further review and consideration(s).

   a. Cases scored 0, S0, or S1, 1 and 2 may be closed by the Medical Director without CPRC review or they may be escalated to CPRC at the Medical Director's discretion.

   b. Cases scored 3 will be presented to CPRC.

E. CPRC Review

1. PQI cases with a recommended outcomes score of 3 shall be presented to the CPRC by a Medical Director following completion of a comprehensive case review.

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a. A comprehensive case review shall include an opportunity for the provider to provide a written clarification/response or a call with the Medical Director assigned the case to correct factual misunderstandings, submit context, describe corrective measures already taken and propose remediation.

b. The Provider shall be notified that the PQI has escalated to CPRC review and the notification shall include an offer for a written clarification/response or a call with the Medical Director assigned the case.

2. CPRC shall discuss presented cases and choose to adopt the recommended outcomes score or assign a different outcome score that reflects the severity of the issue. CPRC is chaired by the CMO or physician designee.

3. PQI cases assigned a severity score of 3 by CPRC shall trigger issuance of a letter to the Provider and, if appropriate, a letter shall be sent to the Provider's contracted Health Network(s) outlining the investigation's findings. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.

F. External Review, Actions, and Provider Notification

~~6.~~ ***CalOptima Health shall utilize an external review entity when*** ~~the following occurs:~~

~~6.1.~~A~~a~~ specific specialty is ~~required for PQI review and the specialty is~~ not represented by a CalOptima Health Medical Director or when a~~:~~

1. ~~A~~ second opinion is ~~determined to be~~ needed.

2. A CalOptima Health CMO, Medical Director or CPRC may recommend and approve further corrective action~~, including but not limited to:~~ if warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.

~~b. A corrective action, which may require~~Once the PQI review process is completed, a PQI Provider ~~to attend a course, provide training to their staff, and/or update policies and procedures;~~

3. ~~An educational or best practice~~resolution letter~~, which may reference an All Plan Letter or other regulatory requirement, a CalOptima~~ will be sent to the Provider or Health ~~policy, and/or national standard of practice;~~Network.

~~c. An on-site audit of the facility and/or medical records;~~

~~d. Medical records review;~~

~~e. Referral to CalOptima Health Fraud, Waste & Abuse, Contracting, or another internal department;~~

~~f. Referral to a regulatory Agency, including but not limited to a~~The PQI Provider resolution letter shall state ~~licensing Agency,~~ the ~~California Department of Public Health, and/or The Joint Commission.~~

a. ~~Require other~~outcome at a level appropriate ~~action(s) as recommended by~~ to the ~~CPRC,~~ circumstances, identify required follow-up ~~to and including the recommendation~~actions if

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any, and, for ~~administrative or for cause termination per CalOptima Health Policy GG.1616: Fair Hearing Process~~confidential cases, blind Member-identifying information.

4. Actions should be applied progressively when appropriate, taking into account patient safety risk, severity, repetition, provider responsiveness, and contractual or regulatory requirements.

~~2.~~5. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical Director and report back to a CalOptima Health Medical Director when the action is completed.

~~7. Once the PQI review process is completed, a resolution letter will be sent to the Provider or Health Network.~~

6. The QI Department shall document all PQI decisions, activity and actions in the Provider's PQI file in care management system, CalOptima Health's PQI system, and shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.

~~a.~~ If the ~~case was a confidential case, the Member information will be blinded in the~~ Provider~~/~~ or Health Network ~~resolution letter.~~

~~3.~~7. ~~If the Provider/Health Network~~ disagrees with the determination, the Provider~~/~~ or Health Network may ~~notify CalOptima Health by contacting~~contact the QI Department and/or ~~by filing a complaint~~pursue the applicable provider compliance process pursuant to CalOptima Health Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

8. If a Provider disagrees with the determination of an adverse action for Medical Disciplinary Cause or Reason requiring a reportable adverse action, the Provider shall be provided hearing rights, in accordance with Policy GG.1616 Fair Hearing Plan for Licentiates.

G. Provider Notification and Case Closure

1. Once the case is leveled with an outcomes score, the case is investigatively closed, and a letter will be sent to the Provider or Health Network notifying them that the investigation is closed.

2. Once all follow-up actions, including monitoring or corrective action verification, are completed, the case is administratively closed, and a letter will be sent to the Provider or Health Network notifying them that the PQI case is closed.

H. Trending and Reporting ~~Requirements and Follow-up Actions~~

~~1. CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant agency within fifteen (15) days after the effective date on which any of the following occurs as a result of an action of the CPRC per CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network:~~

~~a. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.~~

~~b. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.~~

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~~c. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more within any twelve (12) month period, for a medical disciplinary cause or reason.~~

~~2. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank in accordance with CalOptima Health policy CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.~~

1. The QI Department shall use statistical methods and quality improvement models to identify trends, ~~gaps, and potential cause(s) of issue(s) to generate trend reports of PQI cases~~patterns, and causes of PQIs issues and shall report to the CPRC, which includes the CMO, at least every six (6) months.

~~.~~a. ~~Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.~~

~~3. The QI Department shall submit a report to CPRC of all QOC Practitioner-specific complaint cases referred to QI by the GARS Department, evaluating the Practitioner's history of complaints, every six (6) months.~~

~~.a. The QI Department shall submit a monthly report to CPRC of all PQI case findings of PQIs closed the previous month, trend reports, and recommended actions to the CPRC quarterly. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.~~

~~5. The QI Department shall follow up on all actions that the CPRC recommends, track compliance (including requesting evidence that corrective actions have been implemented), and report to the CPRC.~~

~~6. The CalOptima Health QIHEC shall submit quarterly summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' QAC, in accordance with the CalOptima Health QIHETP Plan.~~

~~b.~~a. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.

b. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.

c. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary

d. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.

2. The QI Department shall follow up on all actions recommended by CPRC, track compliance, request evidence of implementation when required, and report status to CPRC until the action is complete.

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3. Reporting Requirements

a. Monthly: The QI Department shall report all PQI cases, closed the previous month, which includes identified adverse events. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.

~~7. The QI Department shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.~~

~~a.~~b. Quarterly: The QI Department shall submit a ~~quarterly~~ report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

c. Quarterly: The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC). Each quarter, the QIHEC shall submit summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP) Plan.

d. At least semi-annually (every 6 months): QI reports to CPRC on all Practitioner-specific Member complaint cases referred to QI (QOC) by the GARS Department, including an evaluation of the history of complaints for all Practitioners.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, §805, 805.01, 809(b) and 1000
B. California Health and Safety Code §-1370
C. CalOptima Health ~~2025~~ Quality Improvement Health Equity Transformation ~~Plan~~Program (QIHETP)
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
F. CalOptima Health Contract with Covered California
G. Covered California Physician Group Services Contract
H. CalOptima Health Policy CC.1201: Member Grievance
~~H.~~I. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
~~I.~~J. CalOptima Health Policy GG.1615: ~~Corrective Action Plan for~~ Practitioners and Organizational Providers Corrective Action Plan for Quality Issues
~~J.~~K. CalOptima Health Policy GG.1616: Fair Hearing Process Plan for Licentiates
~~K.~~L. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
~~L.~~M. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
~~M.~~N. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
~~N.~~O. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
~~O.~~P. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
Q. CalOptima Health Policy HH.1102: Member Grievance
~~P.~~R. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
S. CalOptima Health Policy MA.9002: Enrollee Grievance Process

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~~Q.~~T. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
~~R.~~U. Peer Review Conclusion Letter
~~S.~~V. Title 22, California Code of Regulations (C.C.R.), §-51051
~~T.~~W. Title 28, California Code of Regulations (C.C.R.), §§-1300.70(a)(1) and (3), 1300.70(b)(1)(B) and (C), 1300.70(b)(2)(C), 1300.70(c)
~~U.~~X. Title 42, Code of Federal Regulations (C.F.R), §-422.152 and 438.330

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/06/2026	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

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Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2023	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	04/01/2025	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	05/01/2025	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised	08/01/2026	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised		GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
805.01 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public. 2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely. 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore. A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)
Agency	The relevant state licensing agency having regulatory jurisdiction over the Licentiates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

For 20261105 BOD Review Only

Term	Definition
	OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
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.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	~~Physician~~"Licentiate" is defined in Section 809(b) of the California Business and Professions Code as a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, or dentist, ~~licensed midwife, physician assistant, or nurse practitioner practicing pursuant to BPC §§ 2837.103 or~~

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Term	Definition
	~~2837.104. Licentiate also includes a person~~and persons authorized to practice medicine pursuant to ~~BPC §§~~Business and Professions Code Section 2113 or 2168. "Licentiate" is defined in Section 805 and 805.01 to include licensed midwives, physician assistants, and nurse practitioners for reporting.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. OneCare: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "Peer Review Body" in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
~~Practitioner~~	~~For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in BPC § 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to BPC §§ 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 and its implementing regulations.~~

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Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health 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. 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.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Medi-Cal: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. OneCare: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.

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Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	12/01/1999
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

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I. PURPOSE

This policy defines the process and procedure for intake, investigation, reviewing, leveling (outcome score), escalation, communication and closure of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department involving Providers and Health Networks servicing Members. This policy also identifies when matters are referred to related policies governing corrective action, fair hearing, summary suspension or restriction, and external reporting.

II. POLICY

A. CalOptima Health departments, Health Networks (HNs) and Providers shall refer a PQI to the CalOptima Health QI Department for review and investigation when information suggests that a Member's Quality of Care (QOC), Quality of Service (QOS), patient safety, or related care process may have been compromised.

1. Quality-of-care Grievances are processed under applicable Grievance requirements and routed for PQI review when clinical quality review is indicated, in accordance with Policies: CC.1201: Member Grievance, HH.1102: Member Grievance, and MA.9002: Enrollee Grievance Process.

B. The QI Department shall serve as the single point of intake for PQI cases and shall log a PQI in CalOptima Health's care management system. Appropriately trained and qualified staff, including QI Nurses and CalOptima Health Medical Directors, shall review all PQIs.

C. The QI Department shall manage the PQI process through the following stages: intake and triage, information gathering, clinical and operational review, severity scoring, escalation when indicated, action implementation, provider notification, and case closure.

D. The QI Department shall use provider-facing communications at key process points, including when records or responses are requested, when a case is escalated for Medical Director or Credentialing and Peer Review Committee (CPRC) review, when corrective action is required, and when the case is closed.

E. The QI Department shall conduct timely investigation of each PQI and obtain pertinent documentation needed to evaluate the issue. CalOptima Health shall meet the internal target for investigative closure within one hundred twenty (120) calendar days of receipt of the PQI, unless the

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case needs to be expedited as needed for imminent member-safety risk or the case complexity, confidentiality limitations, external review needs, or related proceedings require additional time.

F. A case shall be considered:

1. Closed for investigation when a severity outcome score has been assigned;

2. Administratively closed when all required follow-up actions, including monitoring or corrective action verification, have been completed.

G. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health CPRC for evaluation and action. Cases assigned Severity Outcome Score 3 shall be presented to CPRC. Other cases may be presented at the Medical Director's discretion.

H. CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws. When a case is designated confidential because a Member chooses anonymity, CalOptima Health shall limit disclosures and blind Member-identifying information in provider-facing communications to the extent practicable and permitted by law.

I. The QI Department shall track, trend, and analyze PQI data by issue, action, and severity level monthly to identify emerging patterns, inform quality improvement activities, and support referral of repeated or significant issues for further review. Analysis and findings shall be reported to CPRC.

J. When the outcome of a PQI review leads to corrective action, summary suspension or restriction, fair hearing rights, or external reporting obligations, CalOptima Health shall follow the applicable requirements in Policies GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues, GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network, GG.1616: Fair Hearing Plan for Licentiates, and GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

K. CalOptima Health maintains a formal, written Quality Improvement Health Equity Transformation Program (QIHETP) approved by CalOptima Health's Quality Assurance Committee (QAC) of the Board and overseen through the CPRC and clinical leadership. The PQI process is a component of this governance structure.

L. CalOptima Health does not delegate PQI review and retains direct responsibility for performance of these activities.

III. PROCEDURE

A. Case Referral Intake

1. In addition to PQI referrals made by Providers and Health Networks, a PQI may be identified and referred to by CalOptima Health departments, committees and subcommittees, Grievance activity, monitoring activity, and other QOC-related activities.

2. Supporting documentation, including correspondence, Grievances, claims data, case management notes, shall accompany the referral whenever available. The referring party shall indicate whether the Member requests anonymity. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.

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3. Upon receipt of a PQI referral, a PQI case shall be opened by the QI Department. PQI cases shall be documented in CalOptima Health's care management system.

4. Cases identified as having imminent danger to the health of any individual shall be immediately referred to the CMO, their physician Designee, or CPRC to summarily suspend or restrict a contracted Provider's practice prerogatives if needed, in accordance with Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network.

B. Information Gathering, Provider Response, and Initial Review

1. The QI Nurse RN shall conduct an initial review of the PQI case and determine the additional information needed to conduct a full investigation.

2. The QI Department shall notify the Provider that a PQI has been opened, the issue related to the PQI and request pertinent medical records and, as applicable, a written response from the Provider(s) and/or Health Network involved rendering medical service(s) in the PQI. Requests shall specify the information sought, the requested submission date, the method of submission, and the CalOptima Health contact for procedural questions.

3. Unless otherwise specified due to urgency, confidentiality, or regulatory requirements, Providers and Health Networks shall be given a standard response timeframe established by department procedure, with extension requests considered for good cause. Failure to respond or submit requested information/documentation may result in review based on available information and may lead to further action, including a corrective action request, when appropriate.

4. The QI Department may collect and review surveys, incident reports, claims data, grievances, and other relevant internal or external information to assess QOC, QOS, and provider performance.

5. If Member anonymity limits the ability to obtain records or provider responses, the QI Department shall document those limitations and proceed using the information reasonably available.

6. The QI Department shall target investigative closure within one hundred and twenty (120) calendar days of PQI receipt. PQIs that are declined grievances shall receive preliminary Medical Director review within thirty (30) calendar days after the PQI is opened.

C. Nurse Review

1. The QI Nurse RN shall conduct a primary review of all PQI cases.

2. QI Nurses may close cases when:

a. The case is determined to be service-related only; and/or

b. No QOC or QOS issue is identified.

3. If a QI Nurse RN does not identify a QOC issue, a second QI Nurse RN shall review the case. If the second QI Nurse RN concurs, the case may be scored, and closed with the action of "No Further Action Required" and/or "Track and Trend."

4. If the QI Nurse identifies a QOC issue, the case shall be referred to a CalOptima Health Medical Director for review. The Medical Director shall assess service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services meet professionally recognized standards of practice.

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D. Medical Director Review and Severity Scoring

1. The Medical Director shall conduct a secondary review of all QOC cases. The Medical Director shall assign an outcome score that reflects the severity of the issue and determine whether further corrective action is warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.

2. CalOptima Health shall use the following outcome categories:

Outcome	Definition	Description
0	**No Impact / No Risk:** Care appears appropriate. No Quality-of-Care or Quality-of-Service issue identified.	• No provider error or lapse in clinical judgment. • Member received appropriate care without delay. • No documentation inaccuracies. • No follow-up action required beyond
1	**Low Impact / Minimal Risk:** Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member	• Slight deviation from best practice or documentation expectations. • Isolated, non-recurrent provider behavior. • No harm or care disruption. • Corrected at provider or supervisor level.
2	**Moderate Impact / Moderate Risk:** Moderate opportunity for improvement. Care deemed below standard or care, or potential for or actual moderate adverse outcome to member	• Moderate deviation from clinical guidelines or evidence-based practice. • Recurring provider documentation errors. • Member experienced a minor delay in care or care coordination. • Requires targeted provider feedback, re-training, or corrective action.
3	**High Impact / Significant Risk:** Significant opportunity for improvement. Care deemed below standard of care, or potential for or actual significant adverse outcome to Member.	• Major deviation from clinical practice guidelines or standards of care. • Member experienced care disruption or temporary adverse outcome. • Provider error impacted diagnostic accuracy or care timeliness. • Requires immediate escalation and further quality review
S0:	**Service Only / Unverified:** Service-related issue, unable to verify.	• No confirmable deviation in provider service or interaction. • Member dissatisfaction is noted, but objective evidence is absent. • No demonstrated impact on care, safety, or required services.
S1	**Service Only Verified:** Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.	• Service lapse confirmed (communication, respect, timeliness, professionalism). • No clinical impact or harm. • May affect member satisfaction or experience.

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3. The Medical Director shall target a case investigative closure or case recommendation to CPRC within 30 days of the PQI case assignment. An additional 30 days is allotted if additional records or documentation is requested by the Medical Director.

4. The case may be closed for investigation by the CalOptima Health Medical Director or be referred and presented to CalOptima Health CPRC for further review and consideration(s).

    a. Cases scored 0, S0, or S1, 1 and 2 may be closed by the Medical Director without CPRC review or they may be escalated to CPRC at the Medical Director's discretion.

    b. Cases scored 3 will be presented to CPRC.

E. CPRC Review

1. PQI cases with a recommended outcomes score of 3 shall be presented to the CPRC by a Medical Director following completion of a comprehensive case review.

    a. A comprehensive case review shall include an opportunity for the provider to provide a written clarification/response or a call with the Medical Director assigned the case to correct factual misunderstandings, submit context, describe corrective measures already taken and propose remediation.

    b. The Provider shall be notified that the PQI has escalated to CPRC review and the notification shall include an offer for a written clarification/response or a call with the Medical Director assigned the case.

2. CPRC shall discuss presented cases and choose to adopt the recommended outcomes score or assign a different outcome score that reflects the severity of the issue. CPRC is chaired by the CMO or physician designee.

3. PQI cases assigned a severity score of 3 by CPRC shall trigger issuance of a letter to the Provider and, if appropriate, a letter shall be sent to the Provider's contracted Health Network(s) outlining the investigation's findings. CalOptima Health reserves the right to notify any appropriate governing, oversight, or regulatory body regarding concerns about any Provider delivering care to CalOptima Health Members.

F. External Review, Actions, and Provider Notification

1. CalOptima Health shall utilize an external review entity when a specific specialty is not represented by a CalOptima Health Medical Director or when a second opinion is needed.

2. A CalOptima Health CMO, Medical Director or CPRC may recommend and approve further corrective action if warranted, in accordance with Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues.

3. Once the PQI review process is completed, a PQI Provider resolution letter will be sent to the Provider or Health Network.

    a. The PQI Provider resolution letter shall state the outcome at a level appropriate to the circumstances, identify required follow-up actions if any, and, for confidential cases, blind Member-identifying information.

4. Actions should be applied progressively when appropriate, taking into account patient safety risk, severity, repetition, provider responsiveness, and contractual or regulatory requirements.

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5. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical Director and report back to a CalOptima Health Medical Director when the action is completed.

6. The QI Department shall document all PQI decisions, activity and actions in the Provider's PQI file in care management system, CalOptima Health's PQI system, and shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.

7. If the Provider or Health Network disagrees with the determination, the Provider or Health Network may contact the QI Department and/or pursue the applicable provider compliance process pursuant to CalOptima Health Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

8. If a Provider disagrees with the determination of an adverse action for Medical Disciplinary Cause or Reason requiring a reportable adverse action, the Provider shall be provided hearing rights, in accordance with Policy GG.1616 Fair Hearing Plan for Licentiates.

G. Provider Notification and Case Closure

1. Once the case is leveled with an outcomes score, the case is investigatively closed, and a letter will be sent to the Provider or Health Network notifying them that the investigation is closed.

2. Once all follow-up actions, including monitoring or corrective action verification, are completed, the case is administratively closed, and a letter will be sent to the Provider or Health Network notifying them that the PQI case is closed.

H. Trending and Reporting

1. The QI Department shall use statistical methods and quality improvement models to identify trends, patterns, and causes of PQIs issues and shall report to the CPRC, which includes the CMO, at least every six (6) months.

   a. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.

   b. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.

   c. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary

   d. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.

2. The QI Department shall follow up on all actions recommended by CPRC, track compliance, request evidence of implementation when required, and report status to CPRC until the action is complete.

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3. Reporting Requirements

   a. Monthly: The QI Department shall report all PQI cases, closed the previous month, which includes identified adverse events. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.

   b. Quarterly: The QI Department shall submit a report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

   c. Quarterly: The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC). Each quarter, the QIHEC shall submit summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP) Plan.

   d. At least semi-annually (every 6 months): QI reports to CPRC on all Practitioner-specific Member complaint cases referred to QI (QOC) by the GARS Department, including an evaluation of the history of complaints for all Practitioners.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, §805, 805.01, 809(b) and 1000
B. California Health and Safety Code §1370
C. CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP)
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
F. CalOptima Health Contract with Covered California
G. Covered California Physician Group Services Contract
H. CalOptima Health Policy CC.1201: Member Grievance
I. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
J. CalOptima Health Policy GG.1615: Practitioners and Organizational Providers Corrective Action Plan for Quality Issues
K. CalOptima Health Policy GG.1616: Fair Hearing Process Plan for Licentiates
L. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
M. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
N. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
O. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
P. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
Q. CalOptima Health Policy HH.1102: Member Grievance
R. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
S. CalOptima Health Policy MA.9002: Enrollee Grievance Process
T. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
U. Peer Review Conclusion Letter
V. Title 22, California Code of Regulations (C.C.R.), §51051

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W. Title 28, California Code of Regulations (C.C.R.), §§1300.70(a)(1) and (3), 1300.70(b)(1)(B) and (C), 1300.70(b)(2)(C), 1300.70(c)
X. Title 42, Code of Federal Regulations (C.F.R), §422.152 and 438.330

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/06/2026	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	02/01/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2023	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare

Rev
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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2025	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	05/01/2025	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised	08/01/2026	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised		GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
805.01 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public. 2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely. 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore. A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)
Agency	The relevant state licensing agency having regulatory jurisdiction over the Licentiates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership.

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Term	Definition
	OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
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.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	"Licentiate" is defined in Section 809(b) of the California Business and Professions Code as a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, or dentist, and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

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Term	Definition
	"Licentiate" is defined in Section 805 and 805.01 to include licensed midwives, physician assistants, and nurse practitioners for reporting.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. OneCare: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "Peer Review Body" in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health 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. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical

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Term	Definition
	centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Medi-Cal: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. OneCare: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.

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Policy:	GG.1615
Title:	**Practitioner and Organizational Provider Corrective Action ~~Plan~~ for ~~Practitioners and Organizational Providers~~Quality Issues**
Department:	Quality Improvement~~Medical Management~~
Section:	Not Applicable~~Quality Improvement~~
CEO Approval:	*/s/*
Effective Date:	08/01/1998
Revised Date:	
Applicable to:	☐ Administrative ~~☐~~☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

~~This policy defines the appropriate Corrective Action process that~~ The purpose of this policy is to establish CalOptima ~~Health shall use~~Health's process for initiating and managing corrective actions for Practitioners and Organizational Providers (~~OPs), including routine monitoring, investigation, and Corrective Action~~ OP) when quality-related ~~to their clinical practice~~concerns are identified. This policy ensures that issues affecting quality of care, patient safety, or performance are addressed in a timely, consistent, and transparent manner to support compliance and continuous improvement across the provider network.

II. POLICY

~~A. The Quality Improvement Health Equity Committee (QIHEC) oversees CalOptima Health's Quality Improvement activities. CalOptima Health's Chief Executive Officer (CEO) and Chief Medical Officer (CMO) are responsible for the Quality of Care of services provided by CalOptima Health.~~

~~B. CalOptima Health's CMO or their physician Designee working through, as appropriate, such standing or ad hoc peer review committee as CalOptima Health may from time to time establish, shall design and implement an effective quality program for the following purposes:~~

~~1. To monitor and assess the quality of professional practice of all Practitioners, and Organizational Providers (OPs); and~~

~~2. To promote high quality of practice by providing education and counseling, issuing letters of admonition, warning or censure, as necessary; and requiring routine monitoring when deemed appropriate by CalOptima Health or the CalOptima Health Credentialing and Peer Review Committee (CPRC).~~

~~C.~~A. CalOptima Health may conduct an investigation and initiate Corrective Action against an individual Practitioner or OP in any Health Network when necessary to ensure the safety of

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CalOptima Health Members, or when the Practitioner or OP fails to meet applicable quality expectations and standards.

~~D. CalOptima Health shall take Corrective Action for either Non-Medical and Medical Disciplinary Cause or Reason, in accordance with the terms and conditions of this Policy.~~

~~E.~~B. Corrective Actions may be imposed based on administrative or clinical findings. Certain investigations and Corrective Actions (*e.g.,* restriction of members or services) taken on the basis of a Medical Disciplinary Cause or Reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB~~).~~), in accordance with CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

~~F. CalOptima Health shall implement any suspension or restriction imposed on a Practitioner for a Medical Disciplinary Cause or Reason in accordance with CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network.~~

~~G. CalOptima Health shall notify a Practitioner and OPs, in writing, in accordance with that Practitioner or OP's contract, but in no case less than ninety (90) calendar days prior to terminating the Practitioner's participation without cause, if appropriate.~~

~~H.~~C. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners and OPs with a Corrective Action process when the Health Network takes or proposes action including routine monitoring, Corrective Action, or investigation.

III. PROCEDURE

~~A. Routine Monitoring~~

~~1. All Practitioners and OPs, regardless of status, shall be subject to routine monitoring.~~

A. Initiation of Corrective Action

Corrective action(s) may be initiated when the

1. ~~The Quality Improvement (QI) Department shall conduct regular patient~~ reviews and ~~studies of~~ evaluations listed below identify a Practitioner or OP exhibiting performance concerns or practice ~~consistent with CalOptima Health general quality assessment and improvement activities and shall investigate~~ patterns that warrant remediation.

a. Quality of Care complaints and Potential Quality Issues (~~PQI) and complaints and Quality of Care incidents~~PQIs) findings in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

b. Regulatory and/or routine audit findings.

~~.~~c. Track and trend data to identify Practitioner and OP quality issues and/or patterns in clinical safety and ~~shall report to the CPRC the results of investigations deemed a Quality of Care issue.~~quality of care

d. ~~The QI Department shall routinely monitor, trend,~~Quality performance data.

e. Outcomes and ~~analyze~~recommendations of the Credentialing and Peer Review Committee (CPRC) meetings.

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~~.~~f. Other Practitioner and ~~OP PQI cases and Grievances~~/or OP quality-related information.

~~4. If any issues or trends emerge with any Practitioner or OP during the monitoring process and to assist them to conform their conduct or practice to the standards of CalOptima Health, the CMO or their physician Designee may issue informal comments or suggestions either orally or in writing or take Corrective Action as outlined in Section III.C. of this Policy.~~

~~5. Informal comments or suggestions shall be confidential and may be issued by the CMO or their physician Designee with or without prior discussion with the recipient and with or without consultation with any CalOptima Health committee.~~

~~a. Such comments or suggestions shall not constitute a restriction of practice prerogatives and shall not be considered to be a "Corrective Action" as that term is used in Section III.C.~~

~~B. Corrective Action for Medical Disciplinary or Non-Medical Disciplinary Cause or Reason~~

~~1. Criteria for Initiation~~

~~a. Any person may provide information to the CMO, QIHEC, CPRC or QI Department about the conduct, performance, or competence of any CalOptima Health Practitioner or OP.~~

2. A request for an ~~investigation or~~a corrective action against a CalOptima Health Practitioner or OP may be initiated by the CalOptima Health Chief Medical Officer (CMO~~,~~), the ~~CEO~~Deputy Chief Medical Officer (DCMO), a Medical Director, the Quality Improvement Health Equity Committee (QIHEC~~,~~), the Credentialing Peer Review Committee (CPRC~~,~~), or the Quality Improvement (QI) Department when upon completion of a review or investigation reliable information indicates that the Practitioner or OP has exhibited acts, demeanor, or conduct reasonably likely to be:

   a. Detrimental to patient safety or to the delivery of quality patient care;

   b. Unethical;

   c. Discriminatory;

   d. Contrary to CalOptima Health policies, rules, and regulations;

   e. Contrary to their CalOptima Health agreement (if applicable~~),~~); or~~,~~

   f. Below applicable CalOptima Health standards.

~~2. Initiation~~

~~a. A request for an investigation must be submitted to the CalOptima Health Quality Improvement Department, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process and must be supported by reference to specific activities or conduct alleged to be detrimental to patient safety or to the delivery of quality patient care, unethical, contrary to CalOptima Health policies or the CalOptima Health contract (if applicable), or below CalOptima Health standards.~~

3. Investigation

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a. If the CalOptima Health CPRC concludes that an investigation is warranted, it shall direct an investigation to be undertaken in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

b. In the event of a formal investigation during the credentialing (or recredentialing) process and the Practitioner or OP withdraws their credentialing application, CalOptima Health shall determine if an 805 report and/or report to the NPDB is required, in accordance with CalOptima Health Policy GG.1657: State Licensing Board and National Practitioner Data Bank (NPDB) Reporting.

~~D.~~B. Corrective Action(s)

~~a. Corrective Action can be taken as a result of issues found through routine monitoring and subsequent PQI investigations in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process, or as a result of issues found during formal investigations.~~

~~b. Corrective Action may be for a non-medical/administrative reason or a Medical, Disciplinary Cause or Reason, and if, for a Medical Disciplinary Cause or reason may result in a reportable action.~~

~~c. At the conclusion~~(s) shall be implemented based on the severity of the ~~investigation, the CPRC shall determine whether to recommend any Corrective Action, and if so, whether the Corrective Action recommended is for a non-medical or Medical Disciplinary Cause or Reason, and will determine if action is reportable pursuant to CalOptima Policy Health GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.~~

~~d. Corrective Action for a Non-Medical Disciplinary Cause or Reason~~ identified quality issue(s) and

~~4.~~1. ~~If a Corrective Action is recommended for a "non-medical disciplinary cause or reason" such as customer service-related issues or delays in responding to medical records requests, the Corrective Action~~ may include~~, without limitation,~~ but are not limited to one or more of the following~~:~~ interventions:

~~a) Deferring action for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant;~~

a. ~~Sending the~~ Peer-to-Peer Discussions;

b. Practitioner or OP a community best practice letter;

~~c) Recommending Practitioner~~ Office staff education~~;~~

~~d.~~c. ~~Recommending office staff~~ and/or training;

d. ~~Requesting~~Practitioner or OP assessment, education and/or training (i.e. UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP);

e. Monitoring through claims and utilization data, internal audits and/or MRR;

f. Focused facility site review (FSR) or Medical Record Review (MRR);

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~~e.~~g. Issuing a written Corrective Action Plan (CAP) with appropriate time frames for correction from the Practitioner demonstrating how the issue will be prevented in the future;

~~f.~~h. ~~Issuing a letter~~Letter of warning, admonition, reprimand, or censure~~, although nothing herein shall be deemed to preclude the CMO, or their physician Designee, the CPRC, or the QIHEC from issuing informal written or oral warnings outside of the mechanism for Corrective Action; or~~;

~~g.~~i. ~~Taking other actions deemed appropriate under the circumstances, including, but not limited to, closing~~Closing physician panels or freezing specialist referrals~~.~~;

~~ii. A Corrective Action for a "non-medical disciplinary cause or reason" shall not constitute a restriction of practice prerogatives, shall not be considered to be a reportable Corrective Action for a "Medical Disciplinary Cause or Reason" as that term is used in Section III.B.4.e. of this Policy, and shall not give rise to hearing rights as outlined in CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners.~~

j. Implementing probation;

k. Summary suspension and/or restriction on provision of services in accordance with CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network;

l. Denial or non-renewal of application for network participation;

m. Terminating participation in CalOptima Health's network; and/or

n. Taking other actions deemed appropriate under the circumstances.

Corrective action(s) may be deferred

~~iii. If no improvement is found after the "non-medical disciplinary" Corrective Action is taken within the specified time frame and the issue addressed in the action is a contractual requirement, the CPRC may take action and/or escalate the case to CalOptima Health's Office of Compliance for further action.~~

~~e. Corrective Action for a "Medical Disciplinary Cause or Reason"~~

~~i. If a Corrective Action is recommended for a "Medical Disciplinary Cause or Reason," CPRC may recommend one or more of the following actions:~~

~~5.~~2. ~~Deferring action~~ for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.

~~b) Sending the Practitioner or OP a best practice letter.~~

~~c) Recommending Practitioner education.~~

~~d) Recommending a written CAP from the Practitioner clearly demonstrating how the issue will be prevented in the future.~~

~~e) Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude the CMO, or their physician Designee, the~~

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~~CPRC, or the QIHEC from issuing informal written or oral warnings outside of the mechanism for Corrective Action.~~

~~f) Recommending mandatory participation in: UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP).~~

~~g) Imposing, or the Practitioner's voluntarily acceptance of, a suspension of or restrictions on a Practitioner's provision of services to CalOptima Health Members.~~

3. Adverse Corrective Action for a "Medical Disciplinary Cause or Reason" generally triggering fair hearing rights in accordance with GG.1616 Fair Hearing Plan for Practitioners include:

   a. Restriction for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period;

   b. Impose a summary suspension if the summary suspension remains in effect for more than fourteen (14) calendar days.

   c. Denial or non-renewal of application for network participation; and

   ~~a.~~d. Terminating participation in CalOptima Health's network.

4. Actions taken for a "Medical Disciplinary Cause or Reason" may ~~require~~:

   a. Initiate a fair hearing process for a Licentiate in accordance with GG.1616: Fair Hearing Process Plan of Licentiates.

   b. Require reporting to the licensing Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting. ~~Reporting under that policy may also be required upon resignation or a leave of absence by a Practitioner from participation in CalOptima Health programs after notice of an investigation initiated for a "Medical or Disciplinary Cause or Reason."~~

   ~~iii. For an action that must be reportable under Section 805/805.01 hearing eligible, as described in CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network, include Medical Disciplinary Cause or Reasons such as:~~

   ~~a) Incompetence;~~

   ~~b) Gross deviation from the standard of care;~~

   ~~c) Self-prescribing or self-administering controlled substances;~~

   ~~d) Abusing drugs or alcohol;~~

   ~~e) Repeated acts of excessive prescribing or providing controlled substances, and~~

   ~~f) Sexual misconduct with a patient.~~

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~~iv. If the investigation concludes there is nothing of merit, no Corrective Action will be taken.~~

~~C. Subsequent Actions~~

~~1. If the CPRC recommends any reportable Corrective Action which would entitle a Practitioner to request a hearing, pursuant to CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, the CPRC shall give the Practitioner written notice of its recommendation, as provided in the CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners prior to imposing such action. A notification shall be sent to the QIHEC for informational purposes only. The CPRC shall also provide notice to CalOptima Health's Office of Compliance and to Legal Affairs. The written notice shall include:~~

~~a. The reasons for the action;~~

~~b. The standards and profiling data used to evaluate the Practitioner; and~~

~~c. Information regarding the Practitioner's appeal rights.~~

~~D. CPRC~~

~~1.~~5. Any ~~CPRC~~corrective action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the CPRC, a Judicial Review Committee, or the QIHEC.

C. Corrective Action Plan (CAP)

1. If a CAP is required to obtain a response along with a plan for Practitioner or OP's remediation to address the quality issue, a QI Nurse in collaboration with the CMO, the Designee, or a Medical Director shall communicate in writing to the Provider a detailed account of the quality issue and/or findings and request a formal written CAP.

2. A response from the Practitioner or OP shall be received within thirty (30) calendar days of receipt.

3. Proposed CAP shall include, at minimum, the following:

a. A description of the quality issue and/or finding

b. The root cause of the deficiency

c. Steps taken to resolve the deficiency

d. Steps taken to avoid reoccurrence

e. Responsible Party

f. Implementation Date

g. Evidence that corrective actions have been implemented

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4. The CMO, the Designee, or a Medical Director shall review and approve (or deny) the Practitioner or OP's proposed CAP to ensure full remediation of the sited deficiency, the provider's understanding of the requirements, and efforts to proactively prevent reoccurrence.

5. The QI Nurse in collaboration with the CMO, the Designee, or a Medical Director shall provide a written response to the Practitioner or OP, either accepting the CAP as provided or rejecting the CAP with the request for additional information.

   a. If a CAP is rejected, a written request describing additional information needed will be sent to the Practitioner or OP and the Practitioner or OP will be provided with the opportunity to resubmit the CAP.

~~2. If If the CPRC does not recommend any Corrective Action which would entitle the CalOptima Health Practitioner to a hearing, pursuant to CalOptima Health Policy GG.1616: Fair Hearing for Practitioners, the CPRC shall either file its report with a recommendation of no further action or take the action that is not reportable.~~

~~3. If the CPRC action(s) is based on any of the following, instead of fifteen (15) calendar days after the effective date of decision, the Section 805/805.01 report must be filed within fifteen (15) calendar days of the final decision or recommendation of the CPRC, without regard to any subsequent hearing. These Medical Disciplinary Causes or Reasons covered by Section 805.01 are:~~

~~a. Incompetence;~~

~~b. Gross deviation from the standard of care;~~

~~c. Self-prescribing or self-administering controlled substances;~~

~~d. Abusing drugs or alcohol;~~

~~e. Repeated acts of excessive prescribing or providing of controlled substances; and~~

~~f. Sexual misconduct with a patient.~~

6. the submitted CAP is rejected three times or if the Practitioner or OP fails to participate in the CAP process, the Provider will be referred to CPRC for further evaluation and recommendations.

~~E.~~D. Action Initiation by QIHEC

1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the QIHEC may direct the CPRC to initiate an investigation or disciplinary action.

2. If the CPRC fails to take action in response to that direction from the QIHEC, the QIHEC may initiate Corrective Action.

~~F.~~E. Automatic ~~Termination, Suspension or Limitation~~and Immediate Adverse Action

1. ~~A Practitioner or OP shall inform the CMO or delegate promptly, and in writing, of any change in their compliance including, without limitation, professional license status, eligibility to participate in any federal health care program, including~~ Adverse action affecting a Practitioner and/or OP participation in the CalOptima Health network, including restriction and termination,

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may occur when as part ongoing monitoring, in accordance with Policy GG.1607: Monitoring Adverse Actions.

~~1. Medi-Cal or Medicare, compliance with CalOptima Health requirements for professional liability insurance, or conviction of a felony.~~

~~2. The Practitioner or OP also must inform the CMO pursuant to this Section, if they are listed in the OIG List of Excluded Individuals/Entities (LEIE), CMS Preclusion List, DHCS Restricted Provider Database, Drug Exclusion list, the System for Award Management (SAM) list, or the Medi-Cal Suspended and Ineligible Provider List.~~

~~3. In the following instances, the Practitioner's or OP's participation may be terminated, suspended, limited, restricted, or placed on probation as described, and such action shall be final, without any of the procedural rights described in CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners. Further, any other action required by CalOptima Health policies and contractual requirements with respect to the Practitioner's participation in (including through the Health Networks) shall be taken as applicable.~~

~~a. Licensure~~

~~i. Whenever a Practitioner's license or other legal credential authorizing practice in California is revoked, suspended, or has lapsed, the Practitioner's participation shall automatically be terminated as of the date such action becomes effective.~~

~~ii. Whenever a Practitioner's license or other legal credential authorizing practice in California is limited or restricted by the applicable licensing or certifying authority, the Practitioner's participation shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term, at least.~~

~~iii. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, their participation status with CalOptima Health shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term, at least.~~

~~iv. Whenever a Practitioner's license or other legal credential is suspended, the Practitioner or OP's participation shall be suspended, at least for the term of the license or other legal credential suspension. CalOptima Health may, at the discretion of the CMO, terminate a Practitioner or OP when the terms of the Practitioner or OP's probation will impact patient care.~~

~~b. Controlled Substances~~

~~i. Whenever a Practitioner's Drug Enforcement Administration (DEA) certificate is revoked, limited, or suspended, or has expired, the Practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and at least throughout its term.~~

~~ii. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medication shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and at least throughout its term. CalOptima Health may, at the discretion of the CMO, terminate a Practitioner when the terms of the Practitioner's probation will impact patient care.~~

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~~e. Medicare/Medi-Cal~~

~~i. If a Practitioner is suspended or excluded from participation or otherwise becomes ineligible to participate in Federal or State health care programs including, without limitation, the Medicare or Medi-Cal program, the Practitioner's participation shall automatically be terminated as of the effective date of the sanction.~~

~~d. Conviction of an Offense~~

~~i. A Practitioner who is convicted of any offense (misdemeanor or felony) that is substantially related to the qualifications, functions, or duties of a physician and surgeons that constitute unprofessional conduct may be suspended or terminated at the recommendation of the CMO or their designee. Such suspension or termination can be effectuated upon conviction at the discretion of the CMO and does not await the criminal conviction becoming final.~~

~~ii. The CMO or their designee shall determine whether the conviction will warrant such suspension or termination depending upon the circumstances of the offense and the relationship between the offense for which the Practitioner is convicted and the qualifications, functions or duties of the Practitioner.~~

~~e. Professional Liability Insurance Eligibility~~

~~i. If, for any reason, a Practitioner fails to maintain professional liability insurance as required by CalOptima Health, the Practitioner's participation shall automatically be suspended until the Practitioner is covered by professional liability insurance acceptable to CalOptima Health.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, Sections 805 & 805.01
B. Health and Safety Code, Division 2, Chapter 2.2, Article 5 Standards, Sections § 1300.67.2.2, § 1367.01 and § 1375.4
~~B.~~C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~C.~~D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~E. CalOptima Health PACE Program Agreement
~~E.~~F. CalOptima Health Compliance Plan
~~F.~~G. CalOptima Health Quality Improvement Program
~~G.~~H. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
~~H.~~I. CalOptima Health Policy GG.1616: Fair Hearing Plan for ~~Practitioners~~Licentiates
~~I.~~J. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
~~J.~~K. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
~~K.~~L. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
~~L.~~M. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network

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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/13/2021	Department of Health Care Services (DHCS)	Fulfilled Requirement
11/06/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/1998	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal
Revised	02/01/2003	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	07/01/2007	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	03/01/2013	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	03/04/2021	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2023	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised		GG.1615	Practitioner and Organizational Provider Corrective Action for Quality Issues	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Corrective Action(s)	Specific identifiable activities or undertakings which address contract deficiencies, noncompliance, or regulatory deficiencies.
Corrective Action Plan (CAP)	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.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC).
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.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health

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Term	Definition
	care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, 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.
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.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	~~A beneficiary~~An individual enrolled in a CalOptima Health program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Potential Quality Issue(s)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
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.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health 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.

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Term	Definition
	OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement	Systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement Health Equity Committee	The CalOptima Health committee that is responsible for the Quality Improvement Health Equity (QIHEC) process.
Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Routine Monitoring	Review of a Practitioner or OP's practice and may include activities for which the Practitioner or OP's only obligation is to provide reasonable advance notice to any CalOptima Health committee or representative of certain patient care procedures or other patient care activity.
Suspension	Effective immediately, the Practitioner's panel will be closed and all CalOptima members will be redirected to another provider in good standing or new authorizations for the Practitioner or OP will cease and all open, unused authorizations will be modified, and members will be reauthorized to another specialist or OP in good standing.

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Policy:	GG.1615
Title:	**Practitioner and Organizational Provider Corrective Action for Quality Issues**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/1998
Revised Date:	
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 CalOptima Health's process for initiating and managing corrective actions for Practitioners and Organizational Providers (OP) when quality-related concerns are identified. This policy ensures that issues affecting quality of care, patient safety, or performance are addressed in a timely, consistent, and transparent manner to support compliance and continuous improvement across the provider network.

II. POLICY

A. CalOptima Health may conduct an investigation and initiate Corrective Action against an individual Practitioner or OP in any Health Network when necessary to ensure the safety of CalOptima Health Members, or when the Practitioner or OP fails to meet applicable quality expectations and standards.

B. Corrective Actions may be imposed based on administrative or clinical findings. Certain investigations and Corrective Actions (*e.g.,* restriction of members or services) taken on the basis of a Medical Disciplinary Cause or Reason may be reportable under Section 805 and to the National Practitioner Data Bank (NPDB), in accordance with CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

C. Health Networks shall have policies and procedures consistent with this Policy that provide Practitioners and OPs with a Corrective Action process when the Health Network takes or proposes action including routine monitoring, Corrective Action, or investigation.

III. PROCEDURE

A. Initiation of Corrective Action

1. Corrective action(s) may be initiated when the reviews and evaluations listed below identify a Practitioner or OP exhibiting performance concerns or practice patterns that warrant remediation.

a. Quality of Care complaints and Potential Quality Issues (PQIs) findings in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

b. Regulatory and/or routine audit findings.

c. Track and trend data to identify Practitioner and OP quality issues and/or patterns in clinical safety and quality of care

d. Quality performance data.

e. Outcomes and recommendations of the Credentialing and Peer Review Committee (CPRC) meetings.

f. Other Practitioner and/or OP quality-related information.

2. A request for an a corrective action against a CalOptima Health Practitioner or OP may be initiated by the CalOptima Health Chief Medical Officer (CMO), the Deputy Chief Medical Officer (DCMO), a Medical Director, the Quality Improvement Health Equity Committee (QIHEC), the Credentialing Peer Review Committee (CPRC), or the Quality Improvement (QI) Department when upon completion of a review or investigation reliable information indicates that the Practitioner or OP has exhibited acts, demeanor, or conduct reasonably likely to be:

a. Detrimental to patient safety or to the delivery of quality patient care;

b. Unethical;

c. Discriminatory;

d. Contrary to CalOptima Health policies, rules, and regulations;

e. Contrary to their CalOptima Health agreement (if applicable); or

f. Below applicable CalOptima Health standards.

3. Investigation

a. If the CalOptima Health CPRC concludes that an investigation is warranted, it shall direct an investigation to be undertaken in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

b. In the event of a formal investigation during the credentialing (or recredentialing) process and the Practitioner or OP withdraws their credentialing application, CalOptima Health shall determine if an 805 report and/or report to the NPDB is required, in accordance with CalOptima Health Policy GG.1657: State Licensing Board and National Practitioner Data Bank (NPDB) Reporting.

B. Corrective Action(s)

1. Corrective Action(s) shall be implemented based on the severity of the identified quality issue(s) and may include but are not limited to one or more of the following interventions:

a. Peer-to-Peer Discussions;

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b. Practitioner or OP a community best practice letter;

c. Office staff education and/or training;

d. Practitioner or OP assessment, education and/or training (i.e. UCSD PACE Competency Assessment, Continuing Professional Development (CPD) courses, Continuing Medical Education (CME) courses, and/or a Physician Enhancement Program (PEP);

e. Monitoring through claims and utilization data, internal audits and/or MRR;

f. Focused facility site review (FSR) or Medical Record Review (MRR);

g. Issuing a written Corrective Action Plan (CAP) with appropriate time frames for correction from the Practitioner demonstrating how the issue will be prevented in the future;

h. Letter of warning, admonition, reprimand, or censure;

i. Closing physician panels or freezing specialist referrals;

j. Implementing probation;

k. Summary suspension and/or restriction on provision of services in accordance with CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network;

l. Denial or non-renewal of application for network participation;

m. Terminating participation in CalOptima Health's network; and/or

n. Taking other actions deemed appropriate under the circumstances.

2. Corrective action(s) may be deferred for a reasonable time, not to exceed one hundred twenty (120) calendar days, where circumstances warrant.

3. Adverse Corrective Action for a "Medical Disciplinary Cause or Reason" generally triggering fair hearing rights in accordance with GG.1616 Fair Hearing Plan for Practitioners include:

a. Restriction for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period;

b. Impose a summary suspension if the summary suspension remains in effect for more than fourteen (14) calendar days.

c. Denial or non-renewal of application for network participation; and

d. Terminating participation in CalOptima Health's network.

4. Actions taken for a "Medical Disciplinary Cause or Reason" may:

a. Initiate a fair hearing process for a Licentiate in accordance with GG.1616: Fair Hearing Process Plan of Licentiates.

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b. Require reporting to the licensing Board under California Business and Professions Code Section 805 and/or 805.01 and/or reporting to the National Provider Data Bank (NPDB) pursuant to CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

5. Any corrective action which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated by the CPRC, a Judicial Review Committee, or the QIHEC.

C. Corrective Action Plan (CAP)

1. If a CAP is required to obtain a response along with a plan for Practitioner or OP's remediation to address the quality issue, a QI Nurse in collaboration with the CMO, the Designee, or a Medical Director shall communicate in writing to the Provider a detailed account of the quality issue and/or findings and request a formal written CAP.

2. A response from the Practitioner or OP shall be received within thirty (30) calendar days of receipt.

3. Proposed CAP shall include, at minimum, the following:

a. A description of the quality issue and/or finding

b. The root cause of the deficiency

c. Steps taken to resolve the deficiency

d. Steps taken to avoid reoccurrence

e. Responsible Party

f. Implementation Date

g. Evidence that corrective actions have been implemented

4. The CMO, the Designee, or a Medical Director shall review and approve (or deny) the Practitioner or OP's proposed CAP to ensure full remediation of the sited deficiency, the provider's understanding of the requirements, and efforts to proactively prevent reoccurrence.

5. The QI Nurse in collaboration with the CMO, the Designee, or a Medical Director shall provide a written response to the Practitioner or OP, either accepting the CAP as provided or rejecting the CAP with the request for additional information.

a. If a CAP is rejected, a written request describing additional information needed will be sent to the Practitioner or OP and the Practitioner or OP will be provided with the opportunity to resubmit the CAP.

6. If the submitted CAP is rejected three times or if the Practitioner or OP fails to participate in the CAP process, the Provider will be referred to CPRC for further evaluation and recommendations.

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D. Action Initiation by QIHEC

1. If the CPRC fails to investigate or take disciplinary action, contrary to the weight of the evidence, the QIHEC may direct the CPRC to initiate an investigation or disciplinary action.

2. If the CPRC fails to take action in response to that direction from the QIHEC, the QIHEC may initiate Corrective Action.

E. Automatic and Immediate Adverse Action

1. Adverse action affecting a Practitioner and/or OP participation in the CalOptima Health network, including restriction and termination, may occur when as part ongoing monitoring, in accordance with Policy GG.1607: Monitoring Adverse Actions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, Sections 805 & 805.01
B. Health and Safety Code, Division 2, Chapter 2.2, Article 5 Standards, Sections § 1300.67.2.2, § 1367.01 and § 1375.4
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Compliance Plan
G. CalOptima Health Quality Improvement Program
H. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
I. CalOptima Health Policy GG.1616: Fair Hearing Plan for Licentiates
J. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
K. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
L. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
M. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/13/2021	Department of Health Care Services (DHCS)	Fulfilled Requirement
11/06/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/1998	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal
Revised	02/01/2003	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	07/01/2007	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	11/01/2011	GG.1615	CalOptima Direct Corrective Action Plan for Practitioners	Medi-Cal
Revised	03/01/2013	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare
Revised	03/04/2021	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2023	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1615	Corrective Action Plan for Practitioners	Medi-Cal OneCare PACE
Revised		GG.1615	Practitioner and Organizational Provider Corrective Action for Quality Issues	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Corrective Action(s)	Specific identifiable activities or undertakings which address contract deficiencies, noncompliance, or regulatory deficiencies.
Corrective Action Plan (CAP)	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.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC).
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.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial

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Term	Definition
	action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, 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.
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.
Judicial Review Committee	An unbiased physician panel responsible for the review of fair hearing cases, deliberation and decision making.
Medical or Disciplinary Cause or Reason	An aspect of a Practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Potential Quality Issue(s)	For the purposes of this policy, means any issue whereby a Member's health may have been compromised by the action or neglect of care at the hand of a practitioner or other provider. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
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.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health 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.

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Term	Definition
	OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement	Systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.
Quality Improvement Health Equity Committee	The CalOptima Health committee that is responsible for the Quality Improvement Health Equity (QIHEC) process.
Quality of Care	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Routine Monitoring	Review of a Practitioner or OP's practice and may include activities for which the Practitioner or OP's only obligation is to provide reasonable advance notice to any CalOptima Health committee or representative of certain patient care procedures or other patient care activity.
Suspension	Effective immediately, the Practitioner's panel will be closed and all CalOptima members will be redirected to another provider in good standing or new authorizations for the Practitioner or OP will cease and all open, unused authorizations will be modified, and members will be reauthorized to another specialist or OP in good standing.

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Policy:	GG.1616
Title:	**Fair Hearing Plan for ~~Practitioners~~Licentiates**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/01/1996
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [~~Effective~~ 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

~~This Policy defines the process that CalOptima Health shall use to provide a fair procedure to Practitioners when adverse actions are proposed to be taken or are taken by CalOptima Health and for which a report is required to be filed under California Business and Professions Code Section 805, or 805.01 and/or with the National Practitioner Data Bank (NPDB).~~

This policy establishes CalOptima Health's fair hearing process for Licentiates when a hearing right is triggered by a reportable or otherwise hearing-eligible adverse action as defined in Business and Professions Code Section 809(b). This policy governs notice of action, hearing request requirements, hearing scheduling, pre-hearing exchange, hearing procedures, Judicial Review Committee (JRC) decision-making, and final action following the hearing. Related processes, including corrective action, summary suspension or restriction, and reporting obligations, are governed by applicable CalOptima Health policies.

II. POLICY

~~A.~~ The following CalOptima Health contracted practitioners are Licentiates as defined in Business and Professions Code Section 809(b) and shall ~~offer Practitioners the procedural~~be given hearing rights ~~set forth in this Policy.~~

~~B. A Peer Review investigation may be initiated~~and the opportunity to appeal certain hearing-eligible adverse decisions made by CalOptima ~~Health whenever reliable information indicates a Practitioner may have engaged in actions that adversely affect, or could adversely affect, the health or welfare of a Member and may call into question Practitioner's competence or professional conduct.~~

A. ~~If CalOptima~~ Health's Credentialing and Peer Review Committee (CPRC~~) believes an adverse action is warranted, as a result of the Peer Review investigation, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process, CalOptima Health shall provide written notice to the Practitioner, which includes their rights to a hearing. Written notice shall be provided within thirty (30) calendar days of the committee's decision of the adverse recommendation.~~):

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~~C. A Practitioner may request a hearing within thirty (30) calendar days from the date of receipt of the written notice of CPRC's recommendation to file an 805 or 805.01 Report and/or with the NPDB for any of the below reasons:~~

1. Physicians and Surgeons;

2. Doctors of Podiatric Medicine;

3. Clinical Psychologists;

4. Marriage and Family Therapists;

5. Clinical Social Workers;

6. Professional Clinical Counselors;

7. Dentists; and

8. And persons authorized to practice under §§ 2113 or 2168.

B. Adverse actions for Medical Disciplinary Cause or Reason generally triggering fair hearing rights include:

~~1. CalOptima Health Initiated Actions:~~

1. Denial or non-renewal of a ~~Practitioner's~~Licentiate's application for ~~CalOptima Health~~network participation ~~for a Medical Disciplinary Cause or Reason~~;

~~a. Non-renewal of a Practitioner's CalOptima Health participation for a Medical Disciplinary Cause or Reason;~~

2. Termination;

~~2.~~3. Restriction ~~on a Practitioner's CalOptima Health participation~~ for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period ~~for a Medical Disciplinary Cause or Reason~~;

~~b. Termination of a Practitioner's CalOptima Health participation for a Medical Disciplinary Cause or Reason; or~~

~~3.~~4. Imposition of summary suspension ~~of a Practitioner's CalOptima Health participation for a Medical Disciplinary Cause or Reason~~ if the summary suspension remains in effect for more than fourteen (14) calendar days.

~~2. Practitioner Initiated Actions:~~

~~1. Resignation or leave of absence by a Practitioner from CalOptima Health participation after:~~

~~a. Notice of an investigation initiated for a Medical Disciplinary Cause or Reason; or~~

~~b. Notice that their application is denied or will be denied for a Medical Disciplinary Cause or Reason.~~

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b. ~~Withdrawal or abandonment of a Practitioner's application for CalOptima Health participation after:~~

i. ~~Notice of an investigation initiated for a Medical Disciplinary Cause or Reason; or~~

ii. ~~Notice that their application is denied or will be denied for a Medical Disciplinary Cause or Reason.~~

c. ~~Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima Health participation after:~~

i. ~~Notice of an investigation initiated for a Medical Disciplinary Cause or Reason; or~~

ii. ~~Notice that their application is denied or will be denied for a Medical Disciplinary Cause or Reason.~~

~~3. Other Disciplinary Actions:~~

~~4.~~5. Any other disciplinary action or recommendation that must be reported pursuant to California Business and Professions Code Section 805 or 805.01, and/or the NPDB.

C. Adverse actions not generally triggering fair hearing rights include educational letters, non-medical corrective action, written corrective action plans (CAPs) that do not independently qualify as reportable adverse action, and administrative actions that do not meet hearing thresholds.

D. CalOptima Health shall administer the fair hearing process in a manner that is timely, procedurally fair, and understandable to the affected Licentiate. Written notices issued under this policy shall include sufficient information for the Licentiate to understand the action being proposed or taken, the basis for that action, the applicable deadlines, and the process for requesting and participating in a hearing.

~~B.~~E. Except as otherwise provided in this Policy, no ~~Practitioner~~Licentiate shall be entitled, as a matter of right, to more than one (1) hearing on any matter.

~~D. With respect to the entirety of this process, technical, insignificant, or non-prejudicial deviations from the procedures set forth in this process shall not be grounds for invalidating the action taken.~~

~~C.~~F. If an adverse action as described in CalOptima Health Policy GG.1607: Monitoring Adverse Actions is identified, or an adverse action for a Medical Disciplinary Cause or Reason is recommended or taken pursuant to CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action ~~Plan~~ for ~~Practitioners and Organizational Providers~~Quality Issues, a ~~Practitioner~~Licentiate shall exhaust all remedies afforded by this Policy before resorting to legal action. If a ~~Practitioner~~Licentiate fails to exhaust all remedies afforded by this Policy, CalOptima Health shall deem such ~~Practitioner~~Licentiate to have waived all hearing and appeal requirements and to have accepted CalOptima Health's action or recommendation.

~~E. This Policy does not apply to the imposition of administrative restrictions, suspensions, or terminations resulting from the Practitioner's failure to meet specific credentialing and contractual obligations, including, without limitation, the failure to meet Minimum Provider Standards according to CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, or~~

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~~where restrictions, suspensions, or terminations are not based on a Medical Disciplinary Cause or Reason.~~

~~D.~~G. The hearing process described in this Policy may not be used to challenge any established law, rule, regulation, policy, or requirement. The Judicial Review Committee (JRC) has no authority to make findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement, and the JRC shall not entertain any such challenge.

~~E.~~H. The JRC shall base its decision on all the evidence produced at the hearing, including all logical and reasonable inferences from the evidence as well as any written statements submitted to the JRC.

~~F. Unless a summary suspension is imposed, if the Practitioner waives their procedural rights, then the recommendation of CalOptima Health shall be submitted for final action, as provided in Section III.A.20.f.~~

I. The fair hearing rights described in this policy are distinct from any provider complaint, reconsideration, or routine dispute process described in other CalOptima Health policies. When an adverse action is hearing-eligible, this policy governs the Licentiate's formal hearing rights.

~~F.~~J. Health Networks shall maintain policies and procedures consistent with this Policy that provide ~~Practitioners~~Licentiate with formal appeal rights ~~when the Health Network takes or proposes adverse action for which an 805 or 805.01 Report and/or an NPDB report is required.~~as defined in Business and Professions Code Section 809(b).

III. PROCEDURE

~~A. Hearing Procedure~~

A. Notice of Action

1. If CalOptima Health takes or recommends ~~any of the final actions~~ an action described in Section II.~~D.~~F.B of this Policy, CalOptima Health shall provide written notice to the ~~Practitioner~~Licentiate as soon as possible ~~after the CPRC takes or recommends the action (~~, but not later than thirty (30) calendar days ~~thereafter),~~after the action or recommendation by the CPRC, and such notice shall include the ~~Practitioner's~~Licentiate's right to a hearing.

2. The notice shall include:

~~i.~~ The action or recommendation ~~against the Practitioner;~~

a. ~~CalOptima Health's obligation to report such action, if adopted, in accordance with Section 805 and 805.01 of the California Business and Professions Code and/or NPDB requirements~~;

b. A brief statement of the reasons for the action or recommendation;

c. The standards and criteria data used to evaluate the Licentiate;

d. CalOptima Health's obligation to report such action, if adopted~~The Practitioner's~~;

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~~c.~~c. The Licentiate's right to request a hearing within thirty (30) calendar days after the date of the notice; and

~~d.~~f. A copy of this Policy.

B. Written Request for Hearing

~~1. A Practitioner may request a hearing by a JRC within~~ The Licentiate shall have thirty (30) calendar days after ~~the date of~~ receipt of the notice ~~described in Section III.A.1 of this Policy.~~

~~2.~~1. ~~The Practitioner shall~~to submit a written request ~~such~~for hearing ~~in writing~~ to the CalOptima Health Chief Medical Officer (CMO), or designee~~, as applicable~~.

~~3. If the Practitioner fails~~Failure to request a hearing within that period shall constitute waiver of the hearing ~~in accordance with Sections III.A.2.a.~~ and ~~III.A.2.b of this Policy, CalOptima Health shall deem such Practitioner to:~~

~~i. Have waived the right to a hearing and to~~ any appellate review ~~for which they may have been eligible under this Policy; and~~

~~4.~~2. ~~Have accepted CalOptima Health's action or final~~ and the proposed action~~, which~~ shall ~~thereupon~~ become effective immediately unless otherwise stated in the notice.

C. Scheduling of Hearing ~~Schedule~~

~~1.~~ Upon timely receipt of a ~~Practitioner's~~ written request ~~for a hearing~~, CalOptima Health shall ~~deliver the request to the CPRC whose decision prompted~~schedule the hearing~~.~~

~~2. Except as set forth below, the hearing shall commence~~ to begin not less than thirty (30) calendar days and not more than sixty (60) calendar days after the ~~date the CMO receives the Practitioner's request for a hearing.~~

~~3.~~1. ~~CalOptima Health may extend the time for commencement of the hearing, but in the event the~~ request is received ~~from a Practitioner who is under summary suspension, the hearing shall be held as soon as arrangements may be reasonably made, so long as the Practitioner has at least thirty (30) calendar days from the date of the notice to prepare for the hearing or provides written waiver of this right;~~, unless:

a. ~~CalOptima Health and the Practitioner may~~A shorter timeframe is required because a summary suspension remains in effect;

~~a.~~b. The parties agree~~,~~ in writing~~,~~ to delay the hearing; or

~~b.~~c. The hearing officer ~~may issue a written decision to delay the hearing on a showing of~~ grants a continuance for good cause.

D. Notice of Hearing ~~(charges).~~with Charges

1. If the ~~Practitioner makes a~~Licentiate timely request ~~for~~ a hearing, CalOptima Health shall provide written notice of the hearing ~~to the Practitioner~~ at least thirty (30) calendar days ~~prior to the date of~~before the hearing date.

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2. ~~Such~~The notice shall include:

   a. The time, date, and location or method of ~~the hearing~~appearance;

   b. The charge(s), reason(s) or basis for the ~~final~~ proposed action taken or recommended, including acts or omissions with which the ~~Practitioner~~Licentiate is charged and a list of the Members whose care is in question, where applicable; or, if the action involves denial of a ~~Practitioner's~~Licentiate's application for participation, the reason(s) for the denial; and

   c. A summary of the ~~Practitioner's~~ Licentiate's hearing rights and ~~the hearing~~ process.

3. CalOptima Health may amend the Notice of Hearing ~~(~~with charges~~)~~ at any time so long as the ~~Practitioner~~Licentiate has a reasonable opportunity to prepare for and present a defense to the Notice of Hearing ~~(~~with charges~~).~~.

E. Judicial Review Committee (JRC)

1. Upon ~~receipt of~~receiving a request for a hearing, the CMO shall appoint a JRC~~, at least a majority of whom shall hold the same professional license as Practitioner (*e.g.*,~~ .

   a. ~~MD, RN, MFT, PsyD). The CMO may designate a chairperson.~~ The JRC shall be composed of ~~not less~~no fewer than three (3) members.

   b. At least a majority of the members shall hold the same professional license as Licentiate (e.g., MD, RN, MFT, PsyD). ~~The JRC shall be composed of individuals who are not~~

   c. Members must not be in direct economic competition with the ~~Practitioner, do~~Licentiate, must not have an apparent bias, ~~do~~must not stand to gain ~~a~~any direct financial benefit from the outcome of the hearing, and ~~shall~~must not have acted as accusers, investigators, fact finders, or initial decision makers ~~in~~ at any prior stage of the matter ~~to be decided at any previous level. Knowledge of~~.

   ~~a.~~d. Possession of knowledge about the underlying facts surrounding the charges does not ~~preclude~~disqualify an individual from serving ~~as a member of~~on the JRC.

~~1.~~2. The CMO may designate a chairperson who shall ~~hear~~address all pre-hearing matters until the selection of a hearing officer is completed.

~~2.~~3. All members of the JRC ~~shall be present at~~are required to attend each hearing session, JRC meeting, and deliberation session unless CalOptima Health and ~~Practitioner~~ Licentiate mutually agree that ~~any one (1) member need not attend~~ a particular member's necessary for a specific session or meeting.

~~3.~~4. ~~The decision~~Decisions of the JRC shall be determined by ~~a~~ majority vote ~~of the members.~~. The numerical vote shall be recorded.

~~4.~~5. ~~The~~All JRC members, including alternates and expert witnesses, shall ~~be paid~~receive a stipend for their service.

~~F. Arbitrator~~

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~~5.~~6. CalOptima Health may propose ~~that an arbitrator be selected in lieu of a JRC. The~~ the use of an arbitrator ~~shall be subject to~~ in lieu of convening a JRC. The appointment of an arbitrator requires the mutual agreement ~~by~~of both CalOptima Health and the ~~Practitioner~~Licentiate. If an arbitrator is ~~used~~selected, the ~~process described in Section III.A.6.b. of this Policy will~~same rights, peer protections and written findings apply.

a. The arbitrator shall meet the same qualifications ~~as the~~required of a hearing officer and ~~will~~shall be selected ~~using~~through a process mutually acceptable to CalOptima Health and the ~~Practitioner~~Licentiate. If the parties are unable to ~~agree~~reach agreement, the arbitrator ~~will be selected pursuant to~~shall be appointed in accordance with the Judicial Arbitration and Mediation Services (JAMS) Comprehensive Arbitration Rules & Procedures. ~~If~~

~~a.~~b. When an arbitrator is ~~selected~~utilized, no separate JRC or hearing officer shall be appointed~~,~~ ~~and all~~. All references ~~in~~within this Policy to the ~~JRC or hearing officer~~ duties and responsibilities of the JRC or hearing officer shall be ~~read~~interpreted as ~~applicable~~applying to the arbitrator.

~~G.~~F. Hearing Officer

~~1.~~ The Chief Medical Officer (CMO) shall appoint a ~~hearing officer to preside at~~ qualified attorney as the hearing~~.~~

~~i. The hearing officer shall be an attorney at law~~ qualified ~~to preside over a hearing and~~ officer, preferably ~~shall have~~with experience in medical staff disciplinary matters.

~~ii.~~ The hearing officer ~~shall:~~

~~a) Not~~must be ~~biased for or against the Practitioner;~~

~~b) Gain~~impartial, receive no direct financial benefit from the outcome~~;~~, and

1. ~~Not~~shall not act as ~~a prosecuting officer or as~~ an advocate for any party.

2. The hearing officer shall ~~advise the Judicial Review Committee (JRC) and~~ participate in ~~the~~ deliberations ~~and act as a legal advisor to the JRC~~ but shall not ~~be entitled to~~ vote.

3. The hearing officer shall ensure ~~that~~ all ~~participants in the hearing~~parties have a ~~reasonable~~fair opportunity to ~~be heard and to~~ present ~~all~~ relevant ~~oral and documentary~~ evidence~~. The hearing officer~~ and shall ~~ensure proper~~maintain decorum ~~is maintained at all times~~throughout the hearing.

4. The hearing officer ~~shall be entitled to determine~~may set the order ~~of, or procedure~~and procedures for~~,~~ presenting evidence and argument ~~during the hearing~~.

5. The hearing officer ~~shall have~~has the ~~authority and~~ discretion~~, in accordance with this Policy,~~ to:

a. Grant continuances;

~~a.~~ Rule on challenges to JRC members~~;~~

b. ~~Rule on challenges to himself~~ or ~~herself serving as the hearing officer;~~ to themselves;

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c. ~~Rule on~~Decide questions ~~raised prior to, or during, the hearing pertaining to matters~~ of law, ~~procedures, or the~~ procedure, and admissibility of evidence;

d. ~~Exercise discretion in limiting the number of~~ Limit witnesses and ~~the overall amount of~~ evidence ~~introduced at the hearing~~as appropriate;

e. Impose ~~any~~ safeguards ~~for the protection of~~to protect the hearing process ~~and, as justice requires, pursuant to~~consistent with California Business and Professions Code Section 809.2;

f. ~~If requested by~~ Assist the JRC, ~~assist in the preparation of the JRC's~~upon request, in preparing its report and recommendations; and

g. Take ~~such~~necessary action ~~as may be warranted by the circumstances~~ if ~~the hearing officer determines that~~ either ~~side in a hearing~~ party is not proceeding ~~in an efficient and expeditious manner.~~ efficiently.

6. The hearing officer ~~will be paid for their services pursuant to~~ shall be compensated under a written agreement ~~between the hearing officer and~~ with CalOptima Health~~. The terms of~~, and the agreement terms shall be disclosed to the Licentiate.

G. Pre-hearing Procedures, Discovery and Evidentiary Exchange

1. Representation

a. If the Licentiate chooses to be accompanied by an attorney, they must provide written notice as early as possible after CalOptima Health takes or recommends the action, and no later than thirty (30) calendar days when submitting the hearing request.

b. CalOptima Health shall not be represented by an attorney if the Licentiate is not represented by an attorney. This does not limit either party's ability to seek legal counsel for preparation before the hearing.

c. If the Licentiate elects not to be represented by an attorney, they may instead be represented by a licensed health care provider who is not an attorney.

2. Notification of Procedural Issues:

a. The Licentiate and the CPRC whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural issues as early as possible.

b. Any objections to pre-hearing decisions may be raised during the hearing, will be preserved for appellate review, and shall be deemed waived if not raised at that time.

3. Discovery

a. Each party may inspect and copy, at their own expense, any relevant documents or information relevant charges in the possession or control of the another party after making a request.

b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing constitutes good cause for a continuance.

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c. At the request of either party, the hearing officer may deny a discovery if:

i. The information pertains solely to individually identifiable Licentiate other than the affected Licentiate;

ii. The denial is necessary to protect CPRC confidentiality; or

iii. The denial is justified in the interest of justice.

d. In resolving discovery disputes, the hearing officer may consider:

i. Whether the information could support or rebut charges;

ii. Whether the information is "exculpatory," in that it would dispute or cast doubt upon the charges, or "inculpatory," in that it would help support the charges or recommendation;

iii. The burden of production; and

iv. The number and scope of other discovery requests submitted.

4. Objections to Previously Unsubmitted Evidence

a. CalOptima Health may object to the introduction of evidence not provided during an credentialing application review or a peer review investigation despite CPRC requests.

b. The hearing officer shall exclude such information from the hearing unless the Licentiate demonstrates prior diligence and an inability to submit the information earlier.

5. Pre-hearing Exchange of Witness and Documents

a. At least ten (10) calendar days before the hearing, the parties shall exchange witness lists and copies of all documents they intend to introduce.

Failure to comply may result in a continuance, limitations on introducing untimely evidence or witnesses, and does not alter each party's responsibility to make all relevant documents available for copying at least thirty (30) calendar days before the hearing.

H. Fair Hearing

1. Record of Hearing

a. A certified shorthand reporter shall record all hearing proceedings, and pre-hearing matters may also be recorded at the hearing officer's discretion. CalOptima Health shall bear the cost of the reporter.

b. All parties may obtain a transcript or recording at their own reasonable expense, in which case both parties shall receive a copy.

2. Rights of Parties

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a. At the hearing, both parties have the right to:

i. Question JRC members or the hearing officer regarding qualifications and raise challenges consistent with this Policy;

ii. Call and examine witnesses;

iii. Present exhibits and relevant documents;

iv. Cross-examine and rebut evidence;

v. Submit a written closing statement; and

vi. Access all information provided to the JRC and to have a record made of the proceedings.

b. The CPRC whose decision prompted the hearing, may examine the Licentiate as if under cross-examination.

c. The hearing officer shall rule on any challenge to a JRC member or to themselves before the hearing continues.

3. Admissibility of Evidence

a. Formal rules of evidence do not apply.

b. Relevant evidence—including hearsay—may be admitted if it is the type reasonably relied upon in serious matters.

c. The JRC members may question witnesses and request that additional testimony as needed.

4. Burden of Going Forward and Burden of Proof

a. CalOptima Health shall first present evidence supporting the charge or recommended action and need not prove every issue for its actions to be considered reasonable and warranted.

b. The ~~Practitioner~~initial applicant Licentiate shall bear the burden of proving, by a preponderance of the evidence, that they possess the qualifications, experience, and competency required for participation. They must provide sufficient information to resolve reasonable doubts and may not introduce previously unsubmitted information unless they demonstrate that it could not have been provided earlier with reasonable diligence.

~~a.~~c. For all other Licentiates, CalOptima Health bears the burden of proving by a preponderance of the evidence that its action or recommendation is reasonable and warranted.

~~1.~~5. Failure to Appear

a. ~~Practitioner's~~Licentiate's failure to appear and proceed at the hearing, absent good cause, shall be deemed voluntary acceptance of the recommendation or action. In such cases, the matter will be forwarded for final action ~~as provided in Section III.A.20.f.~~ following a vote by the JRC to adopt the CalOptima Health recommendation.

~~H. Postponements and Extensions~~

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1. Once a request for a hearing is initiated, postponements and extensions of time beyond the times permitted under this Policy may be allowed by the hearing officer upon a showing of good cause or upon agreement of the parties.

2. Extensions of time necessary to appoint a JRC, hearing officer, and/or arbitrator shall be deemed good cause, as long as both parties proceed in good faith.

H. Representation

1. The hearings provided for in this Policy are for the purpose of intra-professional resolution of matters related to professional conduct, professional competency, or character. Accordingly, the Practitioner is entitled to representation at the hearing as follows:

a. If the Practitioner wishes to be accompanied at the hearing by an attorney, Practitioner shall provide written notice as soon as possible after CalOptima Health takes or recommends the action but not later than thirty (30) calendar days when requesting a hearing.

b. CalOptima Health shall not be accompanied by an attorney if the Practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to assistance of legal counsel for the purpose of preparing for a hearing.

c. If the Practitioner chooses not to be represented at the hearing by an attorney, they may be represented at the hearing by a licensed health care provider who is not also an attorney.

I. Pre-hearing Procedure

a. The Practitioner and the CPRC whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularities as far in advance of the scheduled hearing as possible.

1. The Practitioner or CPRC whose decision prompted the hearing may raise objections to any pre-hearing decision at the hearing.

a. Such objections shall be preserved for consideration at any appellate review hearing.

b. If the Practitioner or CPRC whose decision prompted the hearing fails to raise any objections at the hearing, such objections shall be deemed to have been waived.

J. Discovery

a. The parties may inspect and copy, at their own expense, any documents or other information relevant to the charges in the possession of another party or under its control as soon as practicable after receipt of a request for the same.

1. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing shall be good cause for a continuance of the hearing.

2. The hearing officer, at the request of CalOptima Health or Practitioner, may deny a discovery request if:

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i. The information refers solely to individually identifiable Practitioners other than the affected Practitioner;

b. The denial is justified to protect the confidentiality of the CPRC process; or

ii.i. The denial is justified in the interest of justice.

3. In ruling on discovery disputes, the factors that may be considered include:

a. The information sought may be introduced to support or defend the charges;

b. The information is "exculpatory," in that it would dispute or cast doubt upon the charges, or "inculpatory," in that it would help support the charges or recommendation;

c. The burden on the party of producing the requested information; and

i. Other discovery requests made by the party.

K. Objections to the introduction of evidence previously not produced to CalOptima Health

1. CalOptima Health may object to the introduction of evidence that was not provided during an application review, or during a peer review investigation conducted pursuant to policy, despite the requests of the CPRC whose decision prompted the hearing for the information.

b.a. The hearing officer shall bar such information from the hearing unless the Practitioner is able to prove that they previously acted diligently and could not have submitted the information.

L. Pre-hearing Evidentiary Exchange

1. The parties shall exchange a list of witnesses expected to testify and copies of all documents that each party plans to introduce at the hearing.

2. The parties shall identify witnesses and exchange documents at least ten (10) calendar days prior to the hearing.

a. Failure to comply is good cause for the hearing officer to grant a continuance.

a. This provision shall not affect the initial responsibility of the parties to make all relevant documents available for copying at least thirty (30) calendar days prior to the commencement of the hearing.

b. Failure to comply shall be good cause for the hearing officer to limit introduction of any documents not provided, or witnesses not identified, by the other party in a timely manner.

2.1. Record of Hearing

3. A certified shorthand reporter shall be present to make a record of the hearing proceedings. The pre-hearing proceedings may be placed on the record if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by CalOptima Health.

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2. The Practitioner or CPRC whose decision prompted the hearing shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. In such cases, both parties shall receive a copy of the transcript.

1. Rights of Parties

a. At the hearing, both parties shall have the right to:

i. Ask members of the JRC or the hearing officer questions directly related to determining if the members or the hearing officer meet the qualifications as set forth in Section III.A.5 and Section III.A.7 of this Policy and to challenge the members or the hearing officer;

ii.i. Call and examine witnesses;

iii. Introduce exhibits and other relevant documents;

iv. Cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise rebut any evidence;

v. Provide a written statement at the close of the hearing; and

vi. Be provided with all information made available to the JRC and to have a record made of the proceedings.

b. The CPRC whose decision prompted the hearing shall have the right to call and examine the Practitioner as if under cross-examination.

c. The hearing officer shall rule on any challenge directed at a member of the JRC or the hearing officer prior to the continuation of the proceedings.

2.1. Admissibility of Evidence

a. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence.

b. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is the type of evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

c. The JRC members may question the witnesses and may request that additional witnesses be called if they deem appropriate.

3.1. Burden of Going Forward and Burden of Proof

1. CalOptima Health shall have the initial duty to present evidence that supports the charge or recommended action. CalOptima Health is not required to prove each and every charge or issue before the JRC in order for its actions and/or recommendation(s) to be found reasonable and warranted.

2. An initial applicant Practitioner shall bear the burden of persuading the JRC by a preponderance of the evidence that they possess the requisite qualifications, experience, and competency to participate in CalOptima Health programs.

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a. An initial applicant Practitioner shall provide information that allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications to participate.

b. An initial applicant Practitioner shall not introduce information not produced upon CalOptima Health's request during the application process unless the applicant Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

3. Except as provided above for initial applicants, CalOptima Health shall bear the burden of persuading the JRC, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

4.6. Adjournment and Conclusion

a. The hearing officer may adjourn and reconvene the hearing at the convenience of the participants without special notice.

b. The hearing shall be concluded within a reasonable time, and the hearing officer may set guidelines for the efficient introduction of evidence to achieve a timely conclusion.

c. The partiesParties may submit a written closing statement at the conclusion ofconsistent with the hearing. The closing statement shall conform to the length, officer's established format, and submission guidelines outlined by the hearing officer, in consultation with the JRCdeadlines.

d. Upon conclusion of the presentation of oral and written After all evidence, arguments, and closing statements have been presented, the hearing shall conclude. The JRC shall be concluded. The JRC shall thereupon,then deliberate outside the presence of the parties, conduct its deliberations and render aits decision and accompanyingwritten report.

e.d. Final adjournment shall not occur untiloccurs only after the JRC has completedcompletes its deliberations.

M.I. Decision of the JRC

1. WithinThe JRC shall render its decision, accompanied by a written report, within thirty (6030) calendar days after the conclusion of the evidentiary portion of the hearing, the JRC shall render a decision accompanied by a written report that contains findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision. .

2. If the PractitionerLicentiate is under summary suspension, the time for the decision and report shall be issued within fifteen (15) calendar days.

1.3. The report shall be inwritten report shall include findings of fact and a clear explanation connecting the evidence presented to the decision, with sufficient detail to enableallow the parties and any appellate review body to determineunderstand the basis for the JRC's decisiondetermination on each matter containedcharge in the Notice of Hearing (charges). .

2.4. The JRC shall forward the decision promptly but in not moreto CPRC, the CMO, and the affected Licentiate promptly, and no later than thirty (30) calendar days from the date the

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decision is rendered ~~to the CPRC whose decision prompted the hearing, the CMO, and the affected Practitioner~~.

~~3.~~5. The ~~JRC shall deliver the Practitioner's~~Licentiate's copy of the decision and report shall be delivered by registered or certified mail, return receipt requested, and by first-class mail.

~~4.~~6. The JRC's decision ~~of the JRC shall be considered~~is final. There ~~shall be~~is no right to appeal the decision following the formal hearing.

7. The JRC's decision ~~of the JRC~~ shall be transmitted to the CMO. If the CMO and/or CPRC who initiated the charges, in consultation with legal counsel, ~~is satisfied~~determines that the ~~JRC's~~ decision ~~follows~~resulting from ~~a~~the fair hearing and is consistent with the applicable burden of proof ~~as described above, it shall adopt that~~, the decision shall be adopted as the final action of CalOptima Health, and ~~the decision shall~~ be effective immediately.

~~5.~~8. If the CMO, in consultation with legal counsel, concludes that the JRC's decision does not follow from a fair hearing ~~and/~~or is inconsistent with the applicable burden of proof ~~as described above, then~~, the CMO~~, in consultation with legal counsel,~~ shall ~~proceed as it deems~~take any action necessary ~~and appropriate~~ to address ~~any~~the unfairness and render a decision that is fair and consistent with this ~~policy~~Policy.

~~N.~~J. Reporting

1. CalOptima Health shall comply with the reporting requirements of the California Business and Professions Code and the NPDB in accordance with CalOptima Health ~~policies~~Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

~~b. The CMO and/or CPRC shall file an 805 Report or 805.01 Report within fifteen (15) calendar days and/or report to NPDB with thirty (30) calendar days of the following actions:~~

~~a. CalOptima Health received confirmation that the Practitioner will not request a fair hearing;~~

~~b. CalOptima Health did not receive a fair hearing request from the Practitioner, and thirty (30) calendar days have passed from the date of receipt from the written notice; or~~

~~c. The CMO and/or CPRC adopts the JRC's decision to take any of the actions in II.D.1.a-e.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, §§ 805, 805.01, and 809~~.2~~(b)
B. California Health and Safety Code, §1370
C. California Welfare and Institutions Code, §14000 et seq.
D. CalOptima Health Covered California Physician Group Services Contract
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal

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G. CalOptima Health PACE Program Agreement
H. CalOptima Health Contract with Covered California
I. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
J. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
K. CalOptima Health Policy GG.1615: Practitioner and Organization Providers Corrective Action Plan for ~~Practitioners and Organizational Providers~~Quality Issues
~~L. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards~~
~~M.~~L. Fair Hearing Meeting Notice
~~N.~~M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing
~~O.~~N. Notice of Fair Hearing Rights
~~P.~~O. Title 42, Code of Federal Regulations (C.F.R.), §§422.202, 422.204

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/10/2017	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
06/01/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	03/01/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Reviewed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised	06/01/2017	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2020	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2023	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2026	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE
Revised		GG.1616	Fair Hearing Plan for Licentiates	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
805.01 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public. 2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely. 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore. 4. A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Judicial Review Committee (JRC)	The committee appointed to conduct a hearing based on a request for hearing by ~~Practitioner~~Licentiate, as described in this Policy.
Medical Disciplinary Cause or Reason	Any aspect of a licentiate's competence or conduct that is reasonably likely to be detrimental to patient safety or care.

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~~Member~~	~~An individual enrolled in a CalOptima Health program.~~
~~Minimum Provider Standards~~	~~The standards that must be met in order to submit an application for credentialing, the successful approval of which is a prerequisite to contracting with CalOptima Health or Health Networks in accordance with CalOptima Health Policy GG.1643: Minimum Provider Standards.~~
Term	**Definition**
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Practitioners to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Practitioner may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "peer review body" in BPC § 805(a)(1)(B).
~~Practitioner~~ Licentiate	~~For the purposes of this Policy, "practitioner" shall have the same meaning as~~ "Licentiate" ~~as that term~~ is defined in Section ~~805 and 805.01~~809(b) of the California Business and Professions Code ~~and specifically~~as a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, or dentist, ~~physician assistant~~ and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

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Policy:	GG.1616
Title:	**Fair Hearing Plan for Licentiates**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	04/01/1996
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes CalOptima Health's fair hearing process for Licentiates when a hearing right is triggered by a reportable or otherwise hearing-eligible adverse action as defined in Business and Professions Code Section 809(b). This policy governs notice of action, hearing request requirements, hearing scheduling, pre-hearing exchange, hearing procedures, Judicial Review Committee (JRC) decision-making, and final action following the hearing. Related processes, including corrective action, summary suspension or restriction, and reporting obligations, are governed by applicable CalOptima Health policies.

II. POLICY

A. The following CalOptima Health contracted practitioners are Licentiates as defined in Business and Professions Code Section 809(b) and shall be given hearing rights and the opportunity to appeal certain hearing-eligible adverse decisions made by CalOptima Health's Credentialing and Peer Review Committee (CPRC):

1. Physicians and Surgeons;
2. Doctors of Podiatric Medicine;
3. Clinical Psychologists;
4. Marriage and Family Therapists;
5. Clinical Social Workers;
6. Professional Clinical Counselors;
7. Dentists; and
8. And persons authorized to practice under §§ 2113 or 2168.

B. Adverse actions for Medical Disciplinary Cause or Reason generally triggering fair hearing rights include:

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1. Denial or non-renewal of a Licentiate's application for network participation;

2. Termination;

3. Restriction for a cumulative total of thirty (30) calendar days or more in any twelve (12)-month period;

4. Imposition of summary suspension if the summary suspension remains in effect for more than fourteen (14) calendar days.

5. Any other disciplinary action or recommendation that must be reported pursuant to California Business and Professions Code Section 805 or 805.01, and/or the NPDB.

C. Adverse actions not generally triggering fair hearing rights include educational letters, non-medical corrective action, written corrective action plans (CAPs) that do not independently qualify as reportable adverse action, and administrative actions that do not meet hearing thresholds.

D. CalOptima Health shall administer the fair hearing process in a manner that is timely, procedurally fair, and understandable to the affected Licentiate. Written notices issued under this policy shall include sufficient information for the Licentiate to understand the action being proposed or taken, the basis for that action, the applicable deadlines, and the process for requesting and participating in a hearing.

E. Except as otherwise provided in this Policy, no Licentiate shall be entitled, as a matter of right, to more than one (1) hearing on any matter.

F. If an adverse action as described in CalOptima Health Policy GG.1607: Monitoring Adverse Actions is identified, or an adverse action for a Medical Disciplinary Cause or Reason is recommended or taken pursuant to CalOptima Health Policy GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues, a Licentiate shall exhaust all remedies afforded by this Policy before resorting to legal action. If a Licentiate fails to exhaust all remedies afforded by this Policy, CalOptima Health shall deem such Licentiate to have waived all hearing and appeal requirements and to have accepted CalOptima Health's action or recommendation.

G. The hearing process described in this Policy may not be used to challenge any established law, rule, regulation, policy, or requirement. The Judicial Review Committee (JRC) has no authority to make findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement, and the JRC shall not entertain any such challenge.

H. The JRC shall base its decision on all the evidence produced at the hearing, including all logical and reasonable inferences from the evidence as well as any written statements submitted to the JRC.

I. The fair hearing rights described in this policy are distinct from any provider complaint, reconsideration, or routine dispute process described in other CalOptima Health policies. When an adverse action is hearing-eligible, this policy governs the Licentiate's formal hearing rights.

J. Health Networks shall maintain policies and procedures consistent with this Policy that provide Licentiate with formal appeal rights as defined in Business and Professions Code Section 809(b).

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III. PROCEDURE

A. Notice of Action

1. If CalOptima Health takes or recommends an action described in Section II. B of this Policy, CalOptima Health shall provide written notice to the Licentiate as soon as possible, but not later than thirty (30) calendar days after the action or recommendation by the CPRC, and such notice shall include the Licentiate's right to a hearing.

2. The notice shall include:

   a. The action or recommendation;

   b. A brief statement of the reasons for the action or recommendation;

   c. The standards and criteria data used to evaluate the Licentiate;

   d. CalOptima Health's obligation to report such action, if adopted;

   e. The Licentiate's right to request a hearing within thirty (30) calendar days after the date of the notice; and

   f. A copy of this Policy.

B. Written Request for Hearing

1. The Licentiate shall have thirty (30) calendar days after receipt of the notice to submit a written request for hearing to the CalOptima Health Chief Medical Officer (CMO), or designee.

2. Failure to request a hearing within that period shall constitute waiver of the hearing and any appellate review and the proposed action shall become effective immediately unless otherwise stated in the notice.

C. Scheduling of Hearing

1. Upon timely receipt of a written request, CalOptima Health shall schedule the hearing to begin not less than thirty (30) calendar days and not more than sixty (60) calendar days after the request is received, unless:

   a. A shorter timeframe is required because a summary suspension remains in effect;

   b. The parties agree in writing to delay the hearing; or

   c. The hearing officer grants a continuance for good cause.

D. Notice of Hearing with Charges

1. If the Licentiate timely request a hearing, CalOptima Health shall provide written notice of the hearing at least thirty (30) calendar days before the hearing date.

2. The notice shall include:

   a. The time, date, and location or method of appearance;

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b. The charge(s), reason(s) or basis for the proposed action taken or recommended, including acts or omissions with which the Licentiate is charged and a list of the Members whose care is in question, where applicable; or, if the action involves denial of a Licentiate's application for participation, the reason(s) for the denial; and

c. A summary of the Licentiate's hearing rights and process.

3. CalOptima Health may amend the Notice of Hearing with charges at any time so long as the Licentiate has a reasonable opportunity to prepare for and present a defense to the Notice of Hearing with charges.

E. Judicial Review Committee (JRC)

1. Upon receiving a request for a hearing, the CMO shall appoint a JRC.

a. The JRC shall be composed of no fewer than three (3) members.

b. At least a majority of the members shall hold the same professional license as Licentiate (e.g., MD, RN, MFT, PsyD).

c. Members must not be in direct economic competition with the Licentiate, must not have an apparent bias, must not stand to gain any direct financial benefit from the outcome of the hearing, and must not have acted as accusers, investigators, fact finders, or initial decision makers at any prior stage of the matter.

d. Possession of knowledge about the underlying facts surrounding the charges does not disqualify an individual from serving on the JRC.

2. The CMO may designate a chairperson who shall address all pre-hearing matters until the selection of a hearing officer is completed.

3. All members of the JRC are required to attend each hearing session, JRC meeting, and deliberation session unless CalOptima Health and Licentiate mutually agree that a particular member's necessary for a specific session or meeting.

4. Decisions of the JRC shall be determined by majority vote. The numerical vote shall be recorded.

5. All JRC members, including alternates and expert witnesses, shall receive a stipend for their service.

6. CalOptima Health may propose the use of an arbitrator in lieu of convening a JRC. The appointment of an arbitrator requires the mutual agreement of both CalOptima Health and the Licentiate. If an arbitrator is selected, the same rights, peer protections and written findings apply.

a. The arbitrator shall meet the same qualifications required of a hearing officer and shall be selected through a process mutually acceptable to CalOptima Health and the Licentiate. If the parties are unable to reach agreement, the arbitrator shall be appointed in accordance with the Judicial Arbitration and Mediation Services (JAMS) Comprehensive Arbitration Rules & Procedures.

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b. When an arbitrator is utilized, no separate JRC or hearing officer shall be appointed. All references within this Policy to the duties and responsibilities of the JRC or hearing officer shall be interpreted as applying to the arbitrator.

F. Hearing Officer

1. The Chief Medical Officer (CMO) shall appoint a qualified attorney as the hearing officer, preferably with experience in medical staff disciplinary matters. The hearing officer must be impartial, receive no direct financial benefit from the outcome, and shall not act as an advocate for any party.

2. The hearing officer shall advise the Judicial Review Committee (JRC) and participate in deliberations but shall not vote.

3. The hearing officer shall ensure all parties have a fair opportunity to present relevant evidence and shall maintain decorum throughout the hearing.

4. The hearing officer may set the order and procedures for presenting evidence and argument.

5. The hearing officer has the discretion to:

a. Grant continuances;

b. Rule on challenges to JRC members or to themselves;

c. Decide questions of law, procedure, and admissibility of evidence;

d. Limit witnesses and evidence as appropriate;

e. Impose safeguards to protect the hearing process consistent with California Business and Professions Code Section 809.2;

f. Assist the JRC, upon request, in preparing its report and recommendations; and

g. Take necessary action if either party is not proceeding efficiently.

6. The hearing officer shall be compensated under a written agreement with CalOptima Health, and the agreement terms shall be disclosed to the Licentiate.

G. Pre-hearing Procedures, Discovery and Evidentiary Exchange

1. Representation

a. If the Licentiate chooses to be accompanied by an attorney, they must provide written notice as early as possible after CalOptima Health takes or recommends the action, and no later than thirty (30) calendar days when submitting the hearing request.

b. CalOptima Health shall not be represented by an attorney if the Licentiate is not represented by an attorney. This does not limit either party's ability to seek legal counsel for preparation before the hearing.

c. If the Licentiate elects not to be represented by an attorney, they may instead be represented by a licensed health care provider who is not an attorney.

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2. Notification of Procedural Issues:

a. The Licentiate and the CPRC whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural issues as early as possible.

b. Any objections to pre-hearing decisions may be raised during the hearing, will be preserved for appellate review, and shall be deemed waived if not raised at that time.

3. Discovery

a. Each party may inspect and copy, at their own expense, any relevant documents or information relevant charges in the possession or control of the another party after making a request.

b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing constitutes good cause for a continuance.

c. At the request of either party, the hearing officer may deny a discovery if:

i. The information pertains solely to individually identifiable Licentiate other than the affected Licentiate;

ii. The denial is necessary to protect CPRC confidentiality; or

iii. The denial is justified in the interest of justice.

d. In resolving discovery disputes, the hearing officer may consider:

i. Whether the information could support or rebut charges;

ii. Whether the information is "exculpatory," in that it would dispute or cast doubt upon the charges, or "inculpatory," in that it would help support the charges or recommendation;

iii. The burden of production; and

iv. The number and scope of other discovery requests submitted.

4. Objections to Previously Unsubmitted Evidence

a. CalOptima Health may object to the introduction of evidence not provided during an credentialing application review or a peer review investigation despite CPRC requests.

b. The hearing officer shall exclude such information from the hearing unless the Licentiate demonstrates prior diligence and an inability to submit the information earlier.

5. Pre-hearing Exchange of Witness and Documents

a. At least ten (10) calendar days before the hearing, the parties shall exchange witness lists and copies of all documents they intend to introduce.

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Failure to comply may result in a continuance, limitations on introducing untimely evidence or witnesses, and does not alter each party's responsibility to make all relevant documents available for copying at least thirty (30) calendar days before the hearing.

H. Fair Hearing

1. Record of Hearing

a. A certified shorthand reporter shall record all hearing proceedings, and pre-hearing matters may also be recorded at the hearing officer's discretion. CalOptima Health shall bear the cost of the reporter.

b. All parties may obtain a transcript or recording at their own reasonable expense, in which case both parties shall receive a copy.

2. Rights of Parties

a. At the hearing, both parties have the right to:

i. Question JRC members or the hearing officer regarding qualifications and raise challenges consistent with this Policy;

ii. Call and examine witnesses;

iii. Present exhibits and relevant documents;

iv. Cross-examine and rebut evidence;

v. Submit a written closing statement; and

vi. Access all information provided to the JRC and to have a record made of the proceedings.

b. The CPRC whose decision prompted the hearing, may examine the Licentiate as if under cross-examination.

c. The hearing officer shall rule on any challenge to a JRC member or to themselves before the hearing continues.

3. Admissibility of Evidence

a. Formal rules of evidence do not apply.

b. Relevant evidence—including hearsay—may be admitted if it is the type reasonably relied upon in serious matters.

c. The JRC members may question witnesses and request that additional testimony as needed.

4. Burden of Going Forward and Burden of Proof

a. CalOptima Health shall first present evidence supporting the charge or recommended action and need not prove every issue for its actions to be considered reasonable and warranted.

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b. The initial applicant Licentiate shall bear the burden of proving, by a preponderance of the evidence, that they possess the qualifications, experience, and competency required for participation. They must provide sufficient information to resolve reasonable doubts and may not introduce previously unsubmitted information unless they demonstrate that it could not have been provided earlier with reasonable diligence.

c. For all other Licentiates, CalOptima Health bears the burden of proving by a preponderance of the evidence that its action or recommendation is reasonable and warranted.

5. Failure to Appear

a. Licentiate's failure to appear and proceed at the hearing, absent good cause, shall be deemed voluntary acceptance of the recommendation or action. In such cases, the matter will be forwarded for final action following a vote by the JRC to adopt the CalOptima Health recommendation.

6. Adjournment and Conclusion

a. The hearing officer may adjourn and reconvene the hearing at the convenience of the participants without special notice.

b. The hearing shall be concluded within a reasonable time, and the hearing officer may set guidelines for the efficient introduction of evidence.

c. Parties may submit a written closing statement consistent with the hearing officer's established format and deadlines.

d. After all evidence, arguments, and closing statements have been presented, the hearing shall conclude. The JRC shall then deliberate outside the presence of the parties and render its decision and written report. Final adjournment occurs only after the JRC completes its deliberations.

I. Decision of the JRC

1. The JRC shall render its decision, accompanied by a written report, within thirty (30) calendar days after the conclusion of the evidentiary portion of the hearing.

2. If the Licentiate is under summary suspension, the decision and report shall be issued within fifteen (15) calendar days.

3. The written report shall include findings of fact and a clear explanation connecting the evidence presented to the decision, with sufficient detail to allow the parties and any appellate review body to understand the basis for the JRC's determination on each charge in the Notice of Hearing.

4. The JRC shall forward the decision to CPRC, the CMO, and the affected Licentiate promptly, and no later than thirty (30) calendar days from the date the decision is rendered.

5. The Licentiate's copy of the decision and report shall be delivered by registered or certified mail, return receipt requested, and by first-class mail.

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6. The JRC's decision is final. There is no right to appeal the decision following the formal hearing.

7. The JRC's decision shall be transmitted to the CMO. If the CMO and/or CPRC who initiated the charges, in consultation with legal counsel, determines that the decision resulting from the fair hearing and is consistent with the applicable burden of proof, the decision shall be adopted as the final action of CalOptima Health, and be effective immediately.

8. If the CMO, in consultation with legal counsel, concludes that the JRC's decision does not follow from a fair hearing or is inconsistent with the applicable burden of proof, the CMO shall take any action necessary to address the unfairness and render a decision that is fair and consistent with this Policy.

J. Reporting

1. CalOptima Health shall comply with the reporting requirements of the California Business and Professions Code and the NPDB in accordance with CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, §§ 805, 805.01, and 809(b)
B. California Health and Safety Code, §1370
C. California Welfare and Institutions Code, §14000 et seq.
D. CalOptima Health Covered California Physician Group Services Contract
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Health PACE Program Agreement
H. CalOptima Health Contract with Covered California
I. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
J. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
K. CalOptima Health Policy GG.1615: Practitioner and Organization Providers Corrective Action Plan for Quality Issues
L. Fair Hearing Meeting Notice
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing
N. Notice of Fair Hearing Rights
O. Title 42, Code of Federal Regulations (C.F.R.), §§422.202, 422.204

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/10/2017	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
06/01/2017	Regular Meeting of the CalOptima Board of Directors

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	03/01/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Reviewed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised	06/01/2017	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2020	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/01/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	11/01/2023	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	12/01/2024	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2026	GG.1616	Fair Hearing Plan for Practitioners	Covered California Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised		GG.1616	Fair Hearing Plan for Licentiates	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
805.01 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805.01 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public. 2. The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely. 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason, therefore. 4. A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity – §805(a)(1)(B)(iv)
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Judicial Review Committee (JRC)	The committee appointed to conduct a hearing based on a request for hearing by Licentiate, as described in this Policy.
Medical Disciplinary Cause or Reason	Any aspect of a licentiate's competence or conduct that is reasonably likely to be detrimental to patient safety or care.

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Term	Definition
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Practitioners to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Practitioner may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "peer review body" in BPC § 805(a)(1)(B).
Licentiate	"Licentiate" is defined in Section 809(b) of the California Business and Professions Code as a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, or dentist, and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

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Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

5. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

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a. Delegates shall perform functions that, at minimum, meet the requirements as outlined in this policy.

b. CalOptima Health may accept evidence of ~~NCQA~~National Committee for Quality Assurance (NCQA) Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

C. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring adherence to Credentialing policies ~~are adhered to~~.

D. CalOptima Health's CMO or Designee, or CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health, consistent with Department of Health Care Services (DHCS~~, National Committee for Quality Assurance (~~), NCQA~~), and,~~ Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid (CMS) regulations and standards. The initial Credentialing decision is valid for a period of three (3) years.

E. CalOptima Health and its Delegates shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/~~Re-credentialing~~Recredentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway~~.~~, such as California Department of Public Health (CDPH).

2. CalOptima Health may enroll ~~providers~~practitioners through the screening and enrollment process outlined in Section III.G.~~.~~, in compliance with DHCS requirements, or CalOptima Health may direct network ~~providers~~practitioners to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal but must comply with CalOptima Health's vetting process.

F. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only ~~re-initiate~~reinitiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

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3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

G. CalOptima Health and its Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

   a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

   b. CalOptima Health and its Delegates shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

   a. An independent relationship exists when ~~the~~ CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

H. CalOptima Health and its Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens~~:~~;

   ~~a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.~~

   ~~b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.~~

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

I. CalOptima Health and its Delegates shall credential and recredential the following practitioners including, but not limited to:

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1. Medical Doctor (MD);

2. Doctor of Osteopathy (DO);

3. Doctor of Chiropractic Medicine (DC);

4. Doctor of Dental Surgery (DDS);

5. Doctor of Podiatric Medicine (DPM);

6. Nurse Practitioners (NP); and

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant~~)~~, Midwife, Physical Therapist, etc.)

   a. Behavioral health practitioners, including but not limited to:

      i. Psychiatrists and other physicians;

      ii. Addiction medicine specialists;

      iii. Doctoral or master's level psychologists;

      iv. Master's-level clinical social workers;

      v. Master's-level clinical nurse specialists or psychiatric nurse practitioners; and

      vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors, qualified autism services (QAS) providers also known as applied behavior analysis ~~providers)~~(ABA) practitioners).

J. CalOptima Health and its Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

1. Credentialed and recredentialed NMPs include:

   a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

      i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104;

   b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement, as required by the applicable state of California licensing board, between the NMP and the Organized Health Care System; or

   c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

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2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

K. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or ~~abuse~~Abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families~~; and~~, which is completed by the contracted organization and validated through an attestation;

5. ~~No~~Review of history of liability claims against the practitioner; and

~~5.~~6. Review of federal and state exclusion, sanction, and debarment sources.

L. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists~~)~~, intensivists, pathologists, etc.) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting.

2. Practitioners who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine).

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy MA.5012: Pharmacy Network Credentialing and Access).

4. Covering practitioners who do not have an independent relationship with CalOptima Health.

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer).

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner.

7. Students, residents, and fellows, where applicable.

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

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9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

M. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes and does not credential or recredential medical practitioners who practice exclusively within a FQHC or FQHC Look-Alikes and who provide care for a Member only as a result of the Member being directed to the FQHC or FQHC Look-Alikes.

N. CalOptima Health and its Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36) month cycle to the month, not to the day.

O. CalOptima Health and its Delegates shall ensure that all practitioners maintain current California licensure, as applicable, and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

P. CalOptima Health and its Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

Q. CalOptima Health and its Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and its Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

   a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

   b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

   c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and its Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and its Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

R. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information.

S. CalOptima Health and its Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the ~~respective Credentialing committee~~CMO or its designee or CPRC.

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1. CalOptima Health and its Delegates shall notify the Covered California practitioner within ten (10) business days from receipt of an application and completion of primary source verification to verify receipt and inform the applicant whether the application is complete.

2. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare, or PACE practitioner within thirty (30) calendar days from receipt of an application and completion of primary source verification to verify receipt and inform the applicant whether the application is complete.

3. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will ~~re-initialize~~be discontinued.

T. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

   a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or its Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. CalOptima Health and its Delegates shall utilize the most recent versions of DataSpring (also referred to as the Council for Affordable Quality Health Care (CAQH~~)~~)) credentialing form and processes for Credentialing and Recredentialing. CalOptima Health and/or its Delegates shall only request additional information from an applicant practitioner to clarify and confirm information that is provided on the CAQH credentialing form, including verification of information not specifically disclosed on the practitioner's application.

   c. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

   d. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

   e. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

   f. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health ~~Provider~~Practitioner in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

      i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health ~~Provider~~Practitioner whether the application is complete

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and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

g. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in accordance with DHCS APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

h. Practitioners shall attest to:

   i. Any work history gap that exceeds six (6) months ~~and~~must include written clarification;

   ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

   iii. Lack of present illegal drug use that impairs current ability to practice;

   iv. History of criminal convictions;

   v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

   vi. Current malpractice insurance coverage; and

   vii. The correctness and completeness of the application.

i. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

j. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

k. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

l. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

m. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

   i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

n. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

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o. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days);

c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training;

d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

f. ~~Medicare program enrollment opt-out status (i.e.~~Is not currently on the ~~opt-out~~Medicare Opt Out list~~).~~.

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source ~~(see Attachment A).~~verification table. This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

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i. History of any suspension or curtailment of hospital ~~and~~ clinic privileges.

ii. Any alternative admitting arrangements must be documented in the Credentialing file.

c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

i. DEA and/or CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

ii. This requirement is not applicable for ~~practitioner~~practitioners who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. ~~Practitioner information entered in the~~ National Practitioner Data Bank (NPDB~~), including malpractice history,~~) Continuous Query (CQ) (verification time limit: 120 calendar days) if applicable;

f. No current exclusion or preclusion from participation ~~at any time~~ in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

iii. A felony conviction related to health care fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. ~~No history~~History of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. ~~No history~~History of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include ~~accusations,~~ probation, a previously filed 805 and/or 805.1 report with a licensing board; and

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i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

   a. For ~~doulas and comply~~Doulas, compliance with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

   b. For Community Health Workers (CHW~~) and comply~~), compliance with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the 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:

      i. The source used;

      ii. The date of verification;

      iii. The signature or initials of the person who verified the information;

      iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist; and

      v. The 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:

      i. The source used; and

      ii. The report date, if applicable.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after ~~initial~~ Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

   a. Collect and/or verify, where applicable, at a minimum, all of the information required for ~~initial~~ Credentialing, as set forth in Section III.A. of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

   b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

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i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

iii. Information from quality review activities;

iv. Member satisfaction, if applicable; and

v. Compliance with the terms of the practitioner's contract.

c. All Recredentialing applications must include the attestations as contained in the practitioner's ~~initial~~ Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing ~~review~~.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the credentialing files using either of the following methods or a combination:

a. Credentialing documents signed (or initialed) and dated by the verifier; and

b. A checklist that includes, for each verification:

i. The source used;

ii. The date of verification;

iii. The signature or initials of the person who verified the information;

iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist; and

v. The report date, if applicable.

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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:

i. The source used; and

ii. The report date, if applicable.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards~~),~~, exclusion, sanction and debarment sources, etc.), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing or Recredentialing information obtained from ~~other~~ sources during Credentialing or Recredentialing varies from that provided by the practitioner in the Credentialing or Recredentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

~~Email: mycredentialingupdates@caloptima.org~~
Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

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iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing or Recredentialing verification requirements, or if federal or state law prohibits disclosure.

iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing or Recredentialing file.

b) A practitioner shall be notified via fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon written request.

b) Practitioners can contact the QI Department by ~~phone or e-mail~~ email requesting the status of their application. The QI Department will aim to respond within seven (7) business ~~day~~days of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding credentialing and recredentialing.

2. CalOptima Health shall designate the ~~Credentialing and Peer Review Committee (CPRC)~~CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file~~, and deems the file clean~~.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for ~~final approval and~~ to be reflected in the meeting minutes.

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b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB ~~query~~CQ identifying ~~medical board~~ investigations, or other actions.

i. ~~Non-~~Files that do not meet clean ~~list files~~file criteria will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing or Recredentialing file, which ~~consideration~~ shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in ~~real-time~~person, or as a virtual meeting via telephone or video conference but may not be conducted ~~through e-mail~~via email.

5. Practitioner files identified as not meeting Credentialing or Recredentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or ~~designee~~Designee for review.

a. The CMO or Designee shall review each practitioner file ~~for practitioners who do~~that does not meet Credentialing or Recredentialing criteria and make recommendations regarding ~~approving~~approval or ~~denying~~denial of Credentialing or Recredentialing of the practitioner to the CPRC. For practitioner files which do not ~~meeting~~meet criteria on an administrative basis only, (*e.g.,* does not meet standard requirements to be considered for Credentialing or Recredentialing) the file may be approved or denied by the CMO or Designee.

6. The CPRC shall make a final determination based on the ~~practitioners'~~practitioner's ability to deliver care based on the Credentialing or Recredentialing information collected from the file review process ~~and that~~which is verified prior to ~~making a~~the Credentialing or Recredentialing decision.

a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance;

ii. Acceptance for less than three (3) years;

iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not reportable to the NPDB and/or under 805 or 805.1 requirements;

~~ii.~~iv. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

~~iii.~~v. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

b. CalOptima Health and its Delegates shall make a determination regarding the credentials of a Covered California practitioner within ninety (90) days after receiving a completed practitioner credentialing application, including all required third-party verifications.

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CalOptima Health and its Delegates shall notify a practitioner, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the practitioner's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

i. The practitioner is subject to discipline by the licensing entity for the practitioner.

ii. The practitioner has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

iii. The practitioner has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

c. CalOptima Health shall render a final Credentialing or Recredentialing decision for Medi-Cal, OneCare and PACE practitioners within one hundred twenty (120) calendar days from the date of a completed application, which includes a signed attestation that confirms the correctness and completeness of the application.

i. Application attestations must be signed within ~~the~~ one hundred eighty (180) calendar days prior to the Credentialing or Recredentialing decision. If ~~-~~ the practitioner's attestation expires prior to the Credentialing decision, the practitioner must reattest that the information on the application remains correct and complete, by resigning and redating the attestation.

ii. As of January 1, 2027, CalOptima Health and its Delegates shall notify the practitioner within ten (10) business days to verify receipt and inform the applicant whether the application is complete, which includes collection of the application and third-party verifications.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to re-perform ~~initial~~ Credentialing. However, CalOptima Health must ~~re-verify~~reverify credentials that are no longer within the verification time limit. If the reinstatement ~~would be~~is more than thirty (30) calendar days after termination, CalOptima Health must perform ~~initial~~ Credentialing of such practitioner.

a. Termination ~~of privileges~~ includes failure or refusal to renew a contract or to renew, extend, or reestablish ~~any staff privileges~~such, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and its Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

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b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

2. Prevention:

a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

b. QI Department staff shall remove identifying information, such as name, gender, National Provider Identifier (NPI) and group affiliation, from ~~the~~ practitioner ~~and provider~~ files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the ~~credentialing~~Credentialing or Recredentialing profile with the Contracting, Provider Relations, and Provider Data Management Service (PDMS) ~~Departments~~departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing or Recredentialing process (*i.e.*, education, training, ~~Board Certification~~board certification, and specialty). ~~The~~ PDMS ~~Department~~ will enter the contract and elements of Credentialing or Recredentialing data into CalOptima Health's core business system(s) and/or will verify the Credentialing data in ~~the system, which~~such systems, as needed, and updates pertinent information ~~into the~~for propagation to the printed and/or online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a DHCS PED approval letter as an acceptable form of initial enrollment verification ~~conducted by DHCS~~.

~~2.~~ If a practitioner is not already enrolled with DHCS as a Medi-Cal Fee For Service (FFS) practitioner, ~~then the practitioner screening and enrollment process does not need to be completed by~~ CalOptima Health.

~~3. If a practitioner is not already enrolled with DHCS as a~~ does not ~~Medi-Cal FFS practitioner, then CalOptima Health may~~ complete screening and enrollment established by CalOptima Health.

~~a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.~~

~~b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application.~~

~~c. CalOptima Health shall submit a list of its newly enrolled practitioners every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.~~

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d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each provider type and ensure that the application is reviewed for both accuracy and completeness.

i. CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of the differences between CalOptima Health's and DHCS's provider enrollment processes, including the practitioner's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a practitioner If CalOptima Health chooses to enroll through CalOptima Health, including provisional practitioner status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the practitioner that if CalOptima Health receives any information that impacts the practitioner's eligibility for enrollment, CalOptima Health will suspend processing of the practitioner's enrollment application and make the practitioner aware of the option to apply through DHCS' Medi-Cal FFS practitioner enrollment process.

d) A statement clarifying that in order for the practitioner to participate in the Medi-Cal FFS program, the practitioner must enroll through DHCS, and that enrolling through DHCS will also make the practitioner eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the practitioner's consent in order to share information relating to the practitioner's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each practitioner.

v. CalOptima Health shall maintain all practitioner enrollment documentation in a secure manner to ensure confidentiality of the practitioner's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Practitioners who are unincorporated sole proprietors are not required to disclose the ownership or control information.

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ii. Upon CalOptima Health's request, a practitioner must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the practitioner has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and

b) Any significant business transactions between the practitioner and any wholly-owned supplier, or between the practitioner and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial practitioner applications, including applications for a new practice location, and any applications received in response to a practitioner's reenrollment or revalidation request to determine the practitioner's categorical risk level as limited, moderate, or high.

1. If a practitioner fits within more than one risk level, CalOptima Health must screen the practitioner at the highest risk level.

2. A practitioner's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated practitioner lists, and criminal background checks.

3. CalOptima Health shall not enroll a practitioner who fails to comply with the screening criteria for that practitioner's assigned level of risk.

g. Practitioners are subject to screening based on verification of the following requirements:

1. Limited Risk Practitioners:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

2. Medium Risk Practitioners:

a) Screening requirements of limited risk practitioners; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.

3. High Risk Practitioners:

a) Screening requirements of medium risk practitioners; and

b) Criminal background checks based in part on a set of fingerprints.

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h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:
complete DHCS screening and enrollment,

1. The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.

2. The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.

3. The practitioner has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

4. The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.

i. Additional criteria for high-risk practitioners

4.2. Any person with a five percent (5%) or more direct or indirect ownership and is a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.policy will be updated to reflect the required process(es).

1. CalOptima Health shall direct practitioners to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that practitioners include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

2. When fingerprinting is required, CalOptima Health must furnish the practitioners with the Live Scan form and instructions on where to deliver the completed form.
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3. The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

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~~4. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.~~

~~5. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the practitioner's high-risk designation and the results of the criminal background checks.~~

~~b. Site Visits~~

~~1. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk practitioners to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine the applicant's compliance with state and federal enrollment requirements.~~

~~2. CalOptima Health shall conduct post-enrollment site visits for medium-risk practitioners at least every five (5) years and their high-risk practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.~~

~~3. Onsite visits may be conducted for many reasons, including, but not limited to, the following:~~

~~i. The practitioner was temporarily suspended from the Medi-Cal program;~~

~~a) The practitioner's license was previously suspended;~~

~~b) There is conflicting information in the practitioner's enrollment application;~~

~~c) There is conflicting information in the practitioner's supporting enrollment documentation; and~~

~~d) As part of the practitioner enrollment process, CalOptima Health receives information that raises a suspicion of fraud.~~

Federal and State Database Checks

~~4.~~1. CalOptima Health shall check the following databases to verify the identity and determine the sanction, exclusion, debarment and/or enrollment status of all practitioners:

a. Social Security Administration's Death Master File;

b. National Plan and Provider Enumeration System (NPPES);

c. List of Excluded Individuals/Entities (LEIE);

d. ~~-~~System for Award Management (SAM);

e. CMS' Medicare Exclusion Database (MED);

f. DHCS' Suspended and Ineligible (S&I) Provider List;

g. Restricted Provider Database (RPD);

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h. Preclusion List;

~~g.~~i. Medicare Opt Out report; and

~~h.~~j. CHHS Open Data Portal.

~~5.~~2. CalOptima Health shall also review the SAM, LEIE, RPD, and ~~RPD~~other databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with ~~the~~any sanction, exclusion, or debarment.

~~6.~~3. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

~~c. If CalOptima Health declines to enroll a practitioner, it must refer the practitioner to DHCS for further enrollment options.~~

~~d. If CalOptima Health acquires information, either before or after enrollment, that may impact the practitioner's eligibility to participate in the Medi-Cal program, or a practitioner refuses to submit to the required screening activities, CalOptima Health may decline to accept that practitioner's application.~~

~~e. If at any time CalOptima Health determines that it does not want to contract with a prospective practitioner, and/or that the prospective practitioner will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process of that practitioner.~~

~~f. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Practitioners may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.~~

~~g. All practitioners must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up-to-date.~~

~~h. CalOptima Health shall retain all practitioner screening and enrollment materials and documents for ten (10) years.~~

a. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

~~A. CalOptima Health Primary Source Verification Table~~
Not Applicable

V. REFERENCE(S)

A. 25 United States Code (USC) § 1621t
~~A.~~B. Assembly Bill (AB) 1041
~~B.~~C. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
~~C.~~D. California Evidence Code §1157

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~~D.~~E. California Health & Safety Code §§1374.197, 1374.198, and 1380.2
~~E.~~F. CalOptima Health Contract for Health Care Services
~~F.~~G. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~G.~~H. CalOptima Health Contract with Covered California
~~H.~~I. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~I.~~J. CalOptima Health PACE Program Agreements
~~J.~~K. CalOptima Health Policy GG.1213: Community Health Worker Services
~~K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice~~
L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
~~P. CalOptima Health Policy GG.1619: Delegation Oversight~~
~~Q.~~P. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
~~R.~~Q. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
~~S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers~~
~~T.~~R. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
~~U.~~S. CalOptima Health Policy GG.1707: Doula Services
~~V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint~~
~~W.~~T. CalOptima Health Policy MA.5012: Pharmacy Network: Credentialing and Access
~~X. CalOptima Health Policy MA.9006: Provider Complaint Process~~
~~Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)~~
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 01/02/2025)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. 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
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-015: Immunization Requirements (Supersedes APL 24-008)
U. Department of Managed Health Care (DMHC) Knox Keene Health Care Service Plan Act and Regulations (2026 Edition)
~~U.~~V. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
~~V.~~W. National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days

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05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted
09/28/2026	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised		GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b).

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Term	Definition
	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
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.
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.
Covered California: ~~*Effective 01/01/2027 for CalOptima Health*~~	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.

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Term	Definition
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

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Term	Definition
	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
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.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis,

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Term	Definition
	treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	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 (IHCIA) at 25 USC § 1603.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An individual enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed 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), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.

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Term	Definition
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.
Telehealth	The mode of delivering health care services and public health via 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 the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

5. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

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a. Delegates shall perform functions that, at minimum, meet the requirements as outlined in this policy.

b. CalOptima Health may accept evidence of National Committee for Quality Assurance (NCQA) Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

C. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring adherence to Credentialing policies.

D. CalOptima Health's CMO or Designee, or CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health, consistent with Department of Health Care Services (DHCS), NCQA, Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid (CMS) regulations and standards. The initial Credentialing decision is valid for a period of three (3) years.

E. CalOptima Health and its Delegates shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway, such as California Department of Public Health (CDPH).

2. CalOptima Health may enroll practitioners through the screening and enrollment process outlined in Section III.G., in compliance with DHCS requirements, or CalOptima Health may direct network practitioners to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal but must comply with CalOptima Health's vetting process.

F. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only reinitiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

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G. CalOptima Health and its Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

    a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

    b. CalOptima Health and its Delegates shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

    a. An independent relationship exists when CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

H. CalOptima Health and its Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens;

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

I. CalOptima Health and its Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD);

2. Doctor of Osteopathy (DO);

3. Doctor of Chiropractic Medicine (DC);

4. Doctor of Dental Surgery (DDS);

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5. Doctor of Podiatric Medicine (DPM);

6. Nurse Practitioners (NP); and

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant, Midwife, Physical Therapist, etc.)

    a. Behavioral health practitioners, including but not limited to:

        i. Psychiatrists and other physicians;

        ii. Addiction medicine specialists;

        iii. Doctoral or master's level psychologists;

        iv. Master's-level clinical social workers;

        v. Master's-level clinical nurse specialists or psychiatric nurse practitioners; and

        vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors, qualified autism services (QAS) providers also known as applied behavior analysis (ABA) practitioners).

J. CalOptima Health and its Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

1. Credentialed and recredentialed NMPs include:

    a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

        i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104;

    b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement, as required by the applicable state of California licensing board, between the NMP and the Organized Health Care System; or

    c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

K. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

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1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or Abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families, which is completed by the contracted organization and validated through an attestation;

5. Review of history of liability claims against the practitioner; and

6. Review of federal and state exclusion, sanction, and debarment sources.

L. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists, intensivists, pathologists, etc.) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting.

2. Practitioners who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine).

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy MA.5012: Pharmacy Network Credentialing and Access).

4. Covering practitioners who do not have an independent relationship with CalOptima Health.

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer).

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner.

7. Students, residents, and fellows, where applicable.

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

M. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes and does not credential or recredential medical practitioners who practice exclusively within a FQHC or FQHC Look-Alikes and who provide care for a Member only as a result of the Member being directed to the FQHC or FQHC Look-Alikes.

N. CalOptima Health and its Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36) month cycle to the month, not to the day.

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O. CalOptima Health and its Delegates shall ensure that all practitioners maintain current California licensure, as applicable, and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

P. CalOptima Health and its Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

Q. CalOptima Health and its Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and its Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

   a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

   b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

   c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and its Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and its Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

R. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information.

S. CalOptima Health and its Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the CMO or its designee or CPRC.

1. CalOptima Health and its Delegates shall notify the Covered California practitioner within ten (10) business days from receipt of an application and completion of primary source verification to verify receipt and inform the applicant whether the application is complete.

2. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare, or PACE practitioner within thirty (30) calendar days from receipt of an application and completion of primary source verification to verify receipt and inform the applicant whether the application is complete.

3. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will be discontinued.

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T. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

   a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or its Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. CalOptima Health and its Delegates shall utilize the most recent versions of DataSpring (also referred to as the Council for Affordable Quality Health Care (CAQH)) credentialing form and processes for Credentialing and Recredentialing. CalOptima Health and/or its Delegates shall only request additional information from an applicant practitioner to clarify and confirm information that is provided on the CAQH credentialing form, including verification of information not specifically disclosed on the practitioner's application.

   c. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

   d. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

   e. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

   f. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Practitioner in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

      i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Practitioner whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

   g. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in accordance with DHCS APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

   h. Practitioners shall attest to:

      i. Any work history gap that exceeds six (6) months must include written clarification;

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ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

iii. Lack of present illegal drug use that impairs current ability to practice;

iv. History of criminal convictions;

v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application.

i. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

j. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

k. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

l. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

m. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

n. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

o. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

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ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days);

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training;

   d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

   e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

   f. Is not currently on the Medicare Opt Out list.

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source verification table. This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

   b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

      i. History of any suspension or curtailment of hospital clinic privileges.

      ii. Any alternative admitting arrangements must be documented in the Credentialing file.

   c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

      i. DEA and/or CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

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ii. This requirement is not applicable for practitioners who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. National Practitioner Data Bank (NPDB) Continuous Query (CQ) (verification time limit: 120 calendar days) if applicable;

f. No current exclusion or preclusion from participation in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

iii. A felony conviction related to health care fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. History of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. History of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include probation, a previously filed 805 and/or 805.1 report with a licensing board; and

i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

a. For Doulas, compliance with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

b. For Community Health Workers (CHW), compliance with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

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5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the 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:

        i. The source used;

        ii. The date of verification;

        iii. The signature or initials of the person who verified the information;

        iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist; and

        v. The 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:

        i. The source used; and

        ii. The report date, if applicable.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

    a. Collect and/or verify, where applicable, at a minimum, all of the information required for Credentialing, as set forth in Section III.A. of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

    b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

        i. Member Grievances and Appeals, including number and type during the past three (3) years;

        ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

        iii. Information from quality review activities;

        iv. Member satisfaction, if applicable; and

        v. Compliance with the terms of the practitioner's contract.

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c. All Recredentialing applications must include the attestations as contained in the practitioner's Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

   a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

   b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

5. CalOptima Health, a Delegate, or CVO shall have appropriate documentation in the credentialing files using either of the following methods or a combination:

   a. Credentialing documents signed (or initialed) and dated by the verifier; and

   b. A checklist that includes, for each verification:

      i. The source used;

      ii. The date of verification;

      iii. The signature or initials of the person who verified the information;

      iv. Typed initials are only accepted if there is a unique electronic signature or identifier on the checklist; and

      v. The 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:

      i. The source used; and

      ii. The report date, if applicable.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

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a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards, exclusion, sanction and debarment sources, etc.), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing or Recredentialing information obtained from sources during Credentialing or Recredentialing varies from that provided by the practitioner in the Credentialing or Recredentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing or Recredentialing verification requirements, or if federal or state law prohibits disclosure.

iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing or Recredentialing file.

b) A practitioner shall be notified via fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

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a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon written request.

b) Practitioners can contact the QI Department by email requesting the status of their application. The QI Department will aim to respond within seven (7) business days of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding credentialing and recredentialing.

2. CalOptima Health shall designate the CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

      i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file.

      ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for to be reflected in the meeting minutes.

   b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB CQ identifying investigations, or other actions.

      i. Files that do not meet clean file criteria will be reviewed by CPRC for determination to accept, or deny, the application.

      ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing or Recredentialing file, which shall be reflected in the minutes of the CPRC meeting.

      iii. CPRC meetings and decisions may take place in person, or as a virtual meeting via telephone or video conference but may not be conducted via email.

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5. Practitioner files identified as not meeting Credentialing or Recredentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or Designee for review.

    a. The CMO or Designee shall review each practitioner file that does not meet Credentialing or Recredentialing criteria and make recommendations regarding approval or denial of Credentialing or Recredentialing of the practitioner to the CPRC. For practitioner files which do not meet criteria on an administrative basis only, (*e.g.,* does not meet standard requirements to be considered for Credentialing or Recredentialing) the file may be approved or denied by the CMO or Designee.

6. The CPRC shall make a final determination based on the practitioner's ability to deliver care based on the Credentialing or Recredentialing information collected from the file review process which is verified prior to the Credentialing or Recredentialing decision.

    a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

        i. Acceptance;

        ii. Acceptance for less than three (3) years;

        iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not reportable to the NPDB and/or under 805 or 805.1 requirements;

        iv. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

        v. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

    b. CalOptima Health and its Delegates shall make a determination regarding the credentials of a Covered California practitioner within ninety (90) days after receiving a completed practitioner credentialing application, including all required third-party verifications. CalOptima Health and its Delegates shall notify a practitioner, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the practitioner's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

        i. The practitioner is subject to discipline by the licensing entity for the practitioner.

        ii. The practitioner has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

        iii. The practitioner has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

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c. CalOptima Health shall render a final Credentialing or Recredentialing decision for Medi-Cal, OneCare and PACE practitioners within one hundred twenty (120) calendar days from the date of a completed application, which includes a signed attestation that confirms the correctness and completeness of the application.

i. Application attestations must be signed within one hundred eighty (180) calendar days prior to the Credentialing or Recredentialing decision. If the practitioner's attestation expires prior to the Credentialing decision, the practitioner must reattest that the information on the application remains correct and complete, by resigning and redating the attestation.

ii. As of January 1, 2027, CalOptima Health and its Delegates shall notify the practitioner within ten (10) business days to verify receipt and inform the applicant whether the application is complete, which includes collection of the application and third-party verifications.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to re-perform Credentialing. However, CalOptima Health must reverify credentials that are no longer within the verification time limit. If the reinstatement is more than thirty (30) calendar days after termination, CalOptima Health must perform Credentialing of such practitioner.

a. Termination includes failure or refusal to renew a contract or to renew, extend, or reestablish such, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and its Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

2. Prevention:

a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

b. QI Department staff shall remove identifying information, such as name, gender, National Provider Identifier (NPI) and group affiliation, from practitioner files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the Credentialing or Recredentialing profile with the Contracting, Provider Relations, and Provider Data

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Management Service (PDMS) departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing or Recredentialing process (*i.e.*, education, training, board certification, and specialty). PDMS will enter the contract and elements of Credentialing or Recredentialing data into CalOptima Health's core business system(s) and/or will verify the Credentialing data in such systems, as needed, and updates pertinent information for propagation to the printed and/or online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a DHCS PED approval letter as an acceptable form of initial enrollment verification.

2. If a practitioner is not already enrolled with DHCS as a Medi-Cal Fee For Service (FFS) practitioner CalOptima Health does not complete screening and enrollment established by CalOptima Health. If CalOptima Health chooses to complete DHCS screening and enrollment, this policy will be updated to reflect the required process(es).

H. Federal and State Database Checks

1. CalOptima Health shall check the following databases to verify the identity and determine the sanction, exclusion, debarment and/or enrollment status of all practitioners:

   a. Social Security Administration's Death Master File;

   b. National Plan and Provider Enumeration System (NPPES);

   c. List of Excluded Individuals/Entities (LEIE);

   d. System for Award Management (SAM);

   e. CMS' Medicare Exclusion Database (MED);

   f. DHCS' Suspended and Ineligible (S&I) Provider List;

   g. Restricted Provider Database (RPD);

   h. Preclusion List;

   i. Medicare Opt Out report; and

   j. CHHS Open Data Portal.

2. CalOptima Health shall also review the SAM, LEIE, RPD, and other databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with any sanction, exclusion, or debarment.

3. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

   a. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. 25 United States Code (USC) § 1621t
B. Assembly Bill (AB) 1041
C. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
D. California Evidence Code §1157
E. California Health & Safety Code §§1374.197, 1374.198, and 1380.2
F. CalOptima Health Contract for Health Care Services
G. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
H. CalOptima Health Contract with Covered California
I. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
J. CalOptima Health PACE Program Agreements
K. CalOptima Health Policy GG.1213: Community Health Worker Services
L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
P. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
Q. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
R. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
S. CalOptima Health Policy GG.1707: Doula Services
T. CalOptima Health Policy MA.5012: Pharmacy Network: Credentialing and Access
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 01/02/2025)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. 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
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-015: Immunization Requirements (Supersedes APL 24-008)
U. Department of Managed Health Care (DMHC) Knox Keene Health Care Service Plan Act and Regulations (2026 Edition)
V. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
W. National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

For 2026 IOS POD Review Only

04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted
09/28/2026	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised		GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

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For 2026

IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b).

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Term	Definition
	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
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.
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.
Covered California:	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.

For 2026 10-5 POD Review Only

Term	Definition
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.

For 2026 10-5 BOD Review Only

Term	Definition
	OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
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.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	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 (IHCIA) at 25 USC § 1603.

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Term	Definition
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An individual enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed 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), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.

For 2026 10-30D Review Only

Term	Definition
Telehealth	The mode of delivering health care services and public health via 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 the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the ~~follow~~following shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

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C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee, or the CalOptima Health Credentialing and Peer Review Committee (CPRC) shall have direct responsibility over and shall actively participate in the assessment and ~~Reassessment~~reassessment of an OP. The initial Credentialing decision is valid for a period of three (3) years.

E. ~~The CalOptima Health Credentialing and Peer Review Committee (CPRC)~~The CPRC shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network, consistent with DHCS, National Committee for Quality Assurance (NCQA), and Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and standards. No later than January 1, 2028, the CPRC shall use up-to-date ~~CAQH~~Council for Affordable Quality Healthcare (CAQH) credentialing forms and processes – as applicable and available – to credential and recredential OPs and only request additional information from an OP to clarify and confirm information provided on the applicable and available CAQH credentialing form.

F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers;
5. Chronic Dialysis Clinic;
6. Clinical/Medical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis (End-Stage Renal Disease) Center/Facility;
10. Customized/Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Center (FQHC);
12. FQHC Look-Alikes;
13. Free ~~Clinic~~Clinics;
14. Health Access ~~Program~~Programs;

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15. Home Health Agencies;

16. Hospice and Palliative Care Providers;

17. Hospitals;

18. Indian Health Care Providers or Facilities;

19. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);

20. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

    a. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

21. Non-Emergency Medical Transportation;

22. Prosthetics and Orthotics;

23. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

24. Radiology ~~Center~~Centers (Free Standing);

25. Rehabilitation ~~Center/Clinic~~Centers/Clinics (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

26. Religious Non-Medical Health Care ~~Institution~~Institutions;

27. Residential Care Facilities for the Elderly;

28. Rural Health ~~Clinic;~~Clinics (RHC);

29. Skilled Nursing Facilities/Long Term Care ~~Facility~~Facilities;

30. Surgical ~~Center~~Centers (Free Standing);

31. Transplant Programs (Organ Procurement Organization); ~~and~~

32. Urgent Care ~~Center~~Centers (Free Standing~~).~~); and

33. Medical Groups.

    a. Medical groups shall prohibit employment or contracting with practitioners or OPs (or entities that employ or contract with such practitioners or OPs) 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.

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/

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Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway~~.~~, such as California Department of Public Health (CDPH).

2. CalOptima Health may enroll ~~providers~~Providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. ~~History~~No history of ~~fraud, waste~~Fraud, Waste, and/or ~~abuse~~Abuse;

4. ~~Recent~~No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; ~~and~~

5. ~~History~~Review of history of liability claims against the Provider; and

~~5.~~6. Review of federal and state exclusion, sanction, and debarment sources.

I. CalOptima Health and its Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

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3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and its Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

1. CalOptima Health and its Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and its Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and its Delegates shall confirm:

1. Medi-Cal participation status of the OP; and

2. Medicare participation status for the following OPs:

a. Hospitals;

b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural Health Clinic (RHCs); ~~and~~

m. FQHCs; and

n. FQHC Look-Alikes.

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or its Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision.

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M. No later than January 1, 2027, CalOptima and its Delegates shall make a determination regarding the credentials of a Covered California OP within ninety (90) days after receiving a completed OP credentialing application, including all required third-party verifications. CalOptima and its Delegates shall notify an OP, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the OP's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

1. The OP is subject to discipline by the licensing entity for the OP.

2. The OP has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

3. The OP has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

N. CalOptima and its Delegates shall make a determination regarding the credentials of a Medi-Cal, OneCare or PACE OP within one hundred twenty (120) days after receiving a completed OP credentialing application, including all required third-party verifications.

O. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies CC.1202: CalOptima Health Covered Provider Complaint, HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

P. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: ~~System Controls of Provider~~ Credentialing Information Integrity.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and its Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

i. CalOptima Health and its Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

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ii. CalOptima Health and its Delegates shall notify the Covered California OP within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

iii. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare or PACE OP within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete.

iv. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the OP application withdrawn and will close the Credentialing file, if applicable.

v. If an OP application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (and/or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission (TJC) certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, (DME), prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

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x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

xiv. The ~~California Department of Public Health (~~CDPH~~)~~ for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. ~~A copy of any~~No history of sanctions, ~~Preclusions, Exclusions~~preclusions, exclusions, suspensions, or terminations from Medicare ~~and/or~~, Medi-Cal, or in federal or state health care programs, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

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4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health or its Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

i. Completion of the CalOptima Health Provider training within the last two (2) years;

ii. A facility site audit from a state agency;

iii. No change in five percent (5%) ownership disclosure;

iv. Possession of an active CDPH license and CMS certification; and

v. In good standing as a Regional Center vendor.

c. W-9 request for taxpayer identification number and certification.

d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents~~)~~.

e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

f. No history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare, Medi-Cal, or in federal or state health care programs, as applicable.

C. OP Reassessment

1. CalOptima Health or its Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

b. Incorporate the following data in the decision-making process:

i. Quality review activities, including but not limited to:

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a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

d) Review of medical records, as applicable.

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or its Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or its Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's ~~Credentialing and Peer Review Committee (CPRC)~~CPRC shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no ~~liability~~more than one (1) malpractice claim~~(s)~~) that resulted in ~~settlements~~a settlement or ~~judgments~~judgment greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the OP within the last

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seven (7) years from the date of the assessment, or NPDB query identifying investigations or other actions, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for ~~final approval~~review and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of ~~liability~~more than one malpractice claim~~(s)~~ that resulted in ~~settlements~~settlement, or ~~judgments~~judgment of more than twenty-five thousand dollars ($25,000), paid by or on behalf of the OP.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. OP files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

a. The CMO or Designee shall review each file for OPs who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For OP files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance; ~~or~~

ii. Acceptance for less than three (3) years;

iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not reportable to the NPDB and/or under 805 or 805.1 requirements; or

~~ii.~~iv. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

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b. CalOptima Health shall activate the Covered California OP upon successful approval if the approval occurs prior to the end of the ninety (90)-day timeline from receipt of a completed application.

6. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

~~2.~~ If a Provider is not already enrolled with DHCS as a Medi-Cal ~~FFS~~ Provider, ~~then the Provider screening and enrollment process does not need to be completed by~~ CalOptima Health~~.~~

~~3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may~~ does not complete screening and enrollment established by CalOptima Health.

~~a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all Provider types.~~

~~b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application.~~

~~c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.~~

~~d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.~~

~~i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:~~

~~a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.~~

~~b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider~~If CalOptima Health chooses to ~~enroll through CalOptima Health, including provisional Provider status with~~ complete DHCS screening and enrollment,~~Medi-Cal FFS, processing timelines~~

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of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of the Provider's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12)-month period ending on the date of the request; and,

b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

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i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium Risk Providers

a) Screening requirements of limited risk Providers; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

iii. High Risk Providers:

a) Screening requirements of medium risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been Excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high risk Providers

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4.2. Any person with a five percent (5%) or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.policy will be updated to reflect the required process(es).

i. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

ii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iii. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

iv. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

v. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

b. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Providers at least every five (5) years, and their high-risk Providers every three (3) years or as

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~~necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.~~

~~iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:~~

~~a) The Provider was temporarily suspended from the Medi-Cal program;~~

~~b) The Provider's license was previously suspended;~~

~~c) There is conflicting information in the Provider's enrollment application;~~

~~d) There is conflicting information in the Provider's supporting enrollment documentation; and~~

~~e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.~~

~~c. Federal and State Database Checks~~

~~i. CalOptima Health shall check the following databases to verify the identity and determine the Exclusion and/or enrollment status of all Providers:~~

~~a) Social Security Administration's Death Master File;~~

~~b) National Plan and Provider Enumeration System (NPPES);~~

~~c) List of Excluded Individuals/Entities (LEIE);~~

~~d) System for Award Management (SAM);~~

~~e) CMS' Medicare Exclusion Database (MED);~~

~~f) DHCS' Suspended and Ineligible Provider List;~~

~~g) Restricted Provider Database (RPD); and~~

~~h) CHHS Open Data Portal.~~

~~ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the Exclusion.~~

~~iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.~~

~~d. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.~~

~~e. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses~~

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~~to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.~~

~~f. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.~~

~~g. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.~~

~~h. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.~~

~~i. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.~~

~~j. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Assembly Bill (AB) 1041
B. California Evidence Code, §1157
C. California Health & Safety Code §§1374.198, and 1380.2.
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with the Department of Managed Health Care (DMHC) for the Covered California/Exchange Product
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreement
I. CalOptima Health Policy ~~GG.1355: CalAIM Community Supports~~CC.1202: CalOptima Health Covered Provider Complaint
J. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
L. CalOptima Health Policy GG.1608: Full Scope Site Reviews
~~M.~~ CalOptima Health Policy GG.1659: ~~System Controls of Provider~~ Credentialing Information
~~N.~~M. Integrity CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
~~O.~~N.CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
~~P.~~O.Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)

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~~Q.~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)

~~R.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)

~~S.~~R. 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)

T. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)

U. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)

V. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

W. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers

X. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431

Y. Title 42, United States Code, §1320a-7(a)

Z. Title 45, Code of Federal Regulations, Part 455

AA. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use
09/28/2026	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE

For 09/28/2026 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised		GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
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.

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Term	Definition
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee (CPRC)	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Covered California: An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive

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Term	Definition
	airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; IV pole; tracheostomy tube and supplies; enteral pumps and supplies; bone stimulators; cervical traction (over door); phototherapy blankets for treatment of jaundice in newborns; lactation supplies (one breast pump and the necessary supplies to operate it as prescribed by a doctor for each pregnancy at no cost); and dialysis care equipment for home hemodialysis and home peritoneal dialysis as described in "dialysis care." This definition does not cover neuromodulators; comfort, convenience, or luxury equipment or features; or repair or replacement of equipment due to loss or misuse. Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Medical equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression

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Term	Definition
	of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
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.
Member	An individual enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
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.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a 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.

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Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health 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. OneCare: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

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Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

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C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee, or the CalOptima Health Credentialing and Peer Review Committee (CPRC) shall have direct responsibility over and shall actively participate in the assessment and reassessment of an OP. The initial Credentialing decision is valid for a period of three (3) years.

E. The CPRC shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network, consistent with DHCS, National Committee for Quality Assurance (NCQA), and Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and standards. No later than January 1, 2028, the CPRC shall use up-to-date Council for Affordable Quality Healthcare (CAQH) credentialing forms and processes – as applicable and available – to credential and recredential OPs and only request additional information from an OP to clarify and confirm information provided on the applicable and available CAQH credentialing form.

F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers;
5. Chronic Dialysis Clinic;
6. Clinical/Medical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis (End-Stage Renal Disease) Center/Facility;
10. Customized/Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Center (FQHC);
12. FQHC Look-Alikes;
13. Free Clinics;
14. Health Access Programs;
15. Home Health Agencies;

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16. Hospice and Palliative Care Providers;

17. Hospitals;

18. Indian Health Care Providers or Facilities;

19. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);

20. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

    a. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

21. Non-Emergency Medical Transportation;

22. Prosthetics and Orthotics;

23. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

24. Radiology Centers (Free Standing);

25. Rehabilitation Centers/Clinics (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

26. Religious Non-Medical Health Care Institutions;

27. Residential Care Facilities for the Elderly;

28. Rural Health Clinics (RHC);

29. Skilled Nursing Facilities/Long Term Care Facilities;

30. Surgical Centers (Free Standing);

31. Transplant Programs (Organ Procurement Organization);

32. Urgent Care Centers (Free Standing); and

33. Medical Groups.

    a. Medical groups shall prohibit employment or contracting with practitioners or OPs (or entities that employ or contract with such practitioners or OPs) 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.

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/ Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

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1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway, such as California Department of Public Health (CDPH).

2. CalOptima Health may enroll Providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. No history of Fraud, Waste, and/or Abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families;

5. Review of history of liability claims against the Provider; and

6. Review of federal and state exclusion, sanction, and debarment sources.

I. CalOptima Health and its Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

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3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and its Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

1. CalOptima Health and its Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and its Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and its Delegates shall confirm:

1. Medi-Cal participation status of the OP; and

2. Medicare participation status for the following OPs:

a. Hospitals;

b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural Health Clinic (RHCs);

m. FQHCs; and

n. FQHC Look-Alikes.

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or its Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision.

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M. No later than January 1, 2027, CalOptima and its Delegates shall make a determination regarding the credentials of a Covered California OP within ninety (90) days after receiving a completed OP credentialing application, including all required third-party verifications. CalOptima and its Delegates shall notify an OP, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the OP's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

1. The OP is subject to discipline by the licensing entity for the OP.

2. The OP has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

3. The OP has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

N. CalOptima and its Delegates shall make a determination regarding the credentials of a Medi-Cal, OneCare or PACE OP within one hundred twenty (120) days after receiving a completed OP credentialing application, including all required third-party verifications.

O. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies CC.1202: CalOptima Health Covered Provider Complaint, HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

P. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: Credentialing Information Integrity.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and its Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

i. CalOptima Health and its Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

ii. CalOptima Health and its Delegates shall notify the Covered California OP within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

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iii. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare or PACE OP within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete.

iv. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the OP application withdrawn and will close the Credentialing file, if applicable.

v. If an OP application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (and/or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission (TJC) certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment (DME), prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

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xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

xiv. The CDPH for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. No history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare, Medi-Cal, or in federal or state health care programs, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

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5. CalOptima Health or its Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

i. Completion of the CalOptima Health Provider training within the last two (2) years;

ii. A facility site audit from a state agency;

iii. No change in five percent (5%) ownership disclosure;

iv. Possession of an active CDPH license and CMS certification; and

v. In good standing as a Regional Center vendor.

c. W-9 request for taxpayer identification number and certification.

d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents).

e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

f. No history of sanctions, preclusions, exclusions, suspensions, or terminations from Medicare, Medi-Cal, or in federal or state health care programs, as applicable.

C. OP Reassessment

1. CalOptima Health or its Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

b. Incorporate the following data in the decision-making process:

i. Quality review activities, including but not limited to:

a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

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b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

d) Review of medical records, as applicable.

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or its Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or its Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's CPRC shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no more than one (1) malpractice claim) that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, or NPDB query identifying investigations or other actions, and confirmation that the OP is in good standing with state and federal regulatory agencies.

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i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for review and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of more than one malpractice claim that resulted in settlement, or judgment of more than twenty-five thousand dollars ($25,000), paid by or on behalf of the OP.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. OP files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

a. The CMO or Designee shall review each file for OPs who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For OP files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance;

ii. Acceptance for less than three (3) years;

iii. Acceptance with specific conditions, which shall not be defined as restrictions and are not reportable to the NPDB and/or under 805 or 805.1 requirements; or

iv. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

b. CalOptima Health shall activate the Covered California OP upon successful approval if the approval occurs prior to the end of the ninety (90)-day timeline from receipt of a completed application.

6. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting,

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Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, CalOptima Health does not complete screening and enrollment established by CalOptima Health. If CalOptima Health chooses to complete DHCS screening and enrollment, this policy will be updated to reflect the required process(es).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Assembly Bill (AB) 1041
B. California Evidence Code, §1157
C. California Health & Safety Code §§1374.198, and 1380.2.
D. CalOptima Health Contract for Health Care Services
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with the Department of Managed Health Care (DMHC) for the Covered California/Exchange Product
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreement
I. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint
J. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
L. CalOptima Health Policy GG.1608: Full Scope Site Reviews
M. CalOptima Health Policy GG.1659: Credentialing Information Integrity CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
N. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
R. 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)

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T. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
V. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
W. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers
X. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
Y. Title 42, United States Code, §1320a-7(a)
Z. Title 45, Code of Federal Regulations, Part 455
AA. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use
09/28/2026	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
04/02/2026	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised		GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
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.

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Term	Definition
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee (CPRC)	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
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.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Covered California: An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive

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Term	Definition
	airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; IV pole; tracheostomy tube and supplies; enteral pumps and supplies; bone stimulators; cervical traction (over door); phototherapy blankets for treatment of jaundice in newborns; lactation supplies (one breast pump and the necessary supplies to operate it as prescribed by a doctor for each pregnancy at no cost); and dialysis care equipment for home hemodialysis and home peritoneal dialysis as described in "dialysis care." This definition does not cover neuromodulators; comfort, convenience, or luxury equipment or features; or repair or replacement of equipment due to loss or misuse. Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Medical equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression

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Term	Definition
	of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
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.
Member	An individual enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
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.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a 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.

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Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health 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. OneCare: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

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Quality Policy Updates

Quality Assurance Committee

October 15, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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

New Policy GG.1640: Health Network Pay for Value Program

- Defines requirements and processes for Pay for Value (P4V) program, ensuring alignment with DHCS APL – 24-004[1] and federal regulations, to improve health outcomes and promote health equity
- CalOptima Health shall implement P4V programs for Medi-Cal, OneCare, and Covered California Health Networks and primary care providers for each measurement year (MY), utilizing the Integrated Healthcare Association (IHA) scoring methodology

1. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-004: Quality Improvement and Health Equity Transformation Requirements

New Policy GG.1640: Health Network Pay for Value (PV4) Program Continued

- Establishes the incentives based on performance attainment and year-over-year improvement scores, with corrective actions required for underperformance
- Unearned incentive dollars will be redirected to quality improvement initiatives

Policy Review of GG.1611: Potential Quality Issue (PQI) Review Process

- Summary of key updates:
  - Defined investigative vs. administrative closure.
  - Clarified that PQI review is not a delegated function.
  - Clarified that immediate referral of imminent-danger cases to CMO, physician designee, or CPRC.
  - Updated outcome score table with clearer definitions and descriptions.
  - Added a 30-day target for case closure or CPRC recommendations, with an additional 30 days when supplemental records are needed.

Policy Review of GG.1611: PQI Review Process Continued

- Summary of key updates continued:
  - Required provider notification when cases escalate to CPRC, including opportunity for written clarification or discussion.
  - Clarified progressive application of corrective actions.
  - Clarified frequency and scope of reporting requirements.

Policy Review of GG.1615: Practitioner and Organizational Provider Corrective Action for Quality Issues

- Summary of key updates:
  - Renamed policy to “Practitioner and Organizational Provider Corrective Action Plan of Quality Issues”
  - Expanded the range of corrective actions available to CalOptima Health.
  - Outlined the formal corrective action plan (CAP) process, including defined steps for development, submission, review, and follow-up.

Policy Review of GG.1616: Fair Hearing Plan for Licentiates

- Summary of key updates:
  - Renamed policy to “Fair Hearing Plan for Licentiates.”
  - Updated terminology to reference “licentiate” throughout.
  - Added list of practitioner types included under licentiates.
  - Defined which adverse actions do and do not trigger fair hearing rights.

Policy Review of GG.1650: Credentialing and Recredentialing of Practitioners

- Summary of key updates:
  - Removed the section permitting delegation of Medi-Cal screening and enrollment activities to delegates.
  - Expanded credentialing decision-making authority to the CMO/designee or CPRC and added a three-year credentialing approval period.
  - Expanded the practitioner types subject to credentialing and recredentialing.
  - Strengthened minimum qualification review criteria to include fraud, waste, and abuse history, criminal history, liability claims history, and exclusion/sanction/debarment review.

CalOptima Health

Policy Review of GG.1650: Credentialing and Recredentialing of Practitioners Continued

- Summary of key updates:
  - Clarified credentialing decision and notification timelines, including application expiration if no decision is made within six months.
  - Revised primary source verification and screening requirements, including additional verification elements and updated cross-references.
  - Added standardized documentation requirements for credentialing file verification.
  - Expanded practitioner rights related to review of information and status requests.

CalOptima Health

Policy Review of GG.1650: Credentialing and Recredentialing of Practitioners Continued

- Summary of key updates:
  - Revised CPRC review and decision standards, including clean-file criteria, review process, and decision notification requirements.
  - Clarified post-approval information sharing and provider directory update responsibilities.
  - Expanded required screening databases and ongoing monthly monitoring requirements.
  - Retired Attachment A, CalOptima Health Primary Source Verification Table.

Policy Review of GG.1651: Assessment and Reassessment of Organizational Providers

- Summary of key updates:
  - Clarified assessment/reassessment oversight and added a three-year initial credentialing period.
  - Expanded Medi-Cal screening criteria for providers without a state enrollment pathway.
  - Expanded adverse-action screening across Medicare, Medi-Cal, and other federal/state health care programs.
  - Applied the expanded adverse-action screening standard to ICF/DD assessments.
  - Revised clean-file criteria to add specific malpractice and NPDB thresholds.

CalOptima Health

Policy Review of GG.1651: Assessment and Reassessment of Organizational Providers Continued

- Summary of key updates:
  - Revised CPRC's role from approval to review of clean files.
  - Expanded approval outcomes, including time-limited approval and approval with conditions.

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Approve New CalOptima Health Policies: CC.1401: Authorization and Monitoring of Behavioral Health Treatment Services, CC.1402: Transcranial Magnetic Solution (TMS), and CC.1403: Electroconvulsive Therapy

Contacts

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Recommended Action

Approve the following new CalOptima Health behavioral health policies and procedures related to the CalOptima Health Covered California product:

1. CalOptima Health Policy CC.1401: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services;
2. CalOptima Health Policy CC.1402: Transcranial Magnetic Solution (TMS); and
3. CalOptima Health Policy CC.1403: Electroconvulsive Therapy.

Background

CalOptima Health adopts new policies to ensure organizational practices remain aligned with evolving regulatory requirements, contractual obligations, and quality-of-care expectations across Medi-Cal, OneCare, Covered California, and administrative programs. Staff develops new policies when emerging standards, program changes, or operational needs require clear, consistent guidance to support compliance, promote accountability, and advance CalOptima Health's mission to deliver high-quality, equitable care to members.

Below are summaries for each of the three (3) new CalOptima Health Behavioral Health policies related to the Covered California product.

CalOptima Health Policy CC.1401: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services

This policy establishes CalOptima Health's requirements for authorizing, providing, and monitoring BHT services for CalOptima Health's Covered California (references to Covered California include CalOptima Health's on and off-Exchange products) members. It ensures compliance with state law, including Senate Bill (SB) 855, Health & Safety Code §§1374.721, 1374.73, Department of Managed Health Care (DMHC) guidance, mental health parity mandates, and clinical standards set by nonprofit professional associations such as the Council of Autism Service Providers.

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This policy ensures that members who need BHT services, particularly those with autism spectrum disorder, receive treatment aligned with current clinical standards and state requirements, including SB 855 and DMHC requirements. It establishes a unified authorization process across CalOptima Health's Covered California products by requiring consistent treatment plan standards, defined provider qualifications, and uniform application of clinical review criteria. This includes standardized expectations for functional behavior assessments, treatment plan content, baseline and outcome measures, discharge criteria, and documentation of coordination with Regional Center of Orange County, Local Education Agencies (LEAs), and county behavioral health agencies to prevent duplication of services.

To support operational oversight, the policy establishes clear monitoring and accountability mechanisms. Behavioral Health Integration conducts ongoing reviews of BHT utilization, authorization timeliness, and provider compliance. When CalOptima Health staff identifies deficiencies in treatment planning or service delivery, CalOptima Health may refer a member through established Potential Quality Issue pathways to ensure system-wide quality, regulatory and clinical standards.

Collectively, these elements position CalOptima Health Policy CC.1401 as a standardized, regulatory-aligned framework that supports CalOptima Health's broader efforts to ensure medically necessary access to BHT services, uphold member protections, support parity with medical and surgical benefits, and maintain continuity and coordination across the delivery system. Through this structure, the policy promotes quality, safety, and equitable BHT for the members CalOptima Health serves.

CalOptima Health Policy CC.1402: Transcranial Magnetic Solution (TMS)

The policy incorporates state law, DMHC requirements, and nationally recognized clinical guidelines to establish a standardized framework for determining medical necessity and authorization of TMS for behavioral health conditions. It aligns with SB 855 and Health and Safety Code §1374.721 and incorporates the most current nonprofit professional guidance, including standards from the Canadian Network for Mood and Anxiety Treatments (CANMAT), the American Psychological Association, the American Psychiatric Association, and the Clinical TMS Society. These sources collectively define evidence-based clinical indications, treatment parameters, and documentation expectations for TMS modalities such as repetitive transcranial magnetic stimulation (rTMS), deep transcranial magnetic stimulation (dTMS), and FDA-cleared theta-burst protocols.

Across the Covered California product, the policy establishes uniform criteria for clinical appropriateness, including diagnosis requirements, treatment resistance thresholds, use of FDA-cleared devices, contraindication screening, and measurement-based symptom tracking. The policy operationalizes consistent review standards for major depressive disorder, obsessive-compulsive disorder, and tobacco use disorder, as well as investigational review pathways for emerging or maintenance protocols in alignment with CalOptima Health Policy GG.1102: Experimental & Investigational Service Coverage. It also specifies the required documentation providers must include with TMS requests, including medication history, psychotherapy trials, symptom scores, and previous TMS outcomes.

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To support operational oversight and regulatory compliance, the policy integrates CalOptima Health's authorization framework through references to CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers and CalOptima Health Policy CC.1600: Authorization and Processing of Referrals, ensuring consistent processing, documentation, and review across participating networks. It further establishes a structured clinical verification process to confirm medical necessity, prevent inappropriate variation in TMS utilization, and ensure that treatment protocols follow the most recent nonprofit clinical guidelines and FDA-cleared parameters.

Collectively, these elements position CalOptima Health Policy CC.1402 as a standardized, regulatory-aligned TMS framework that supports CalOptima Health's broader strategy to ensure equitable access to medically necessary behavioral health services, and that TMS is used safely, consistently, and only when clinically appropriate, while still allowing flexibility for different treatment protocols when supported by clinical evidence.

CalOptima Health Policy CC.1403: Electroconvulsive Therapy

The policy integrates state mental health parity requirements, state law, and nationally recognized clinical standards to establish a unified framework for determining the medical necessity and authorization of electroconvulsive therapy (ECT) for CalOptima Health's Covered California members. It reflects statutory mandates under SB 855 and Health & Safety Code §1374.721 and incorporates current nonprofit professional guidance from the CANMAT, the American Psychological Association, the American Psychiatric Association, and the American Academy of Child and Adolescent Psychiatry.

This policy establishes how CalOptima Health determines when ECT is medically necessary for its Covered California members, including criteria for ECT, age thresholds, qualifying diagnoses, treatment-resistance requirements, and detailed evaluation expectations. The policy distinguishes primary clinical indications such as severe or life-threatening major depressive episodes, psychotic depression, catatonia, acute nutritional compromise, and pregnancy-related severe depression, from secondary indications such as treatment-resistant depression, bipolar disorders, and schizophrenia. It further outlines treatment-related considerations (*e.g.*, medication intolerance, urgent symptom severity, prior positive response) to ensure standardized, equitable review of clinical appropriateness.

The framework also incorporates nationally accepted procedural guidance by describing what ECT is and when it is considered appropriate, including treatment frequency (typically two to three times per week) and primary conditions such as severe major depression, catatonia, and other treatment-resistant disorders. It also includes special considerations for minors, including consent, capacity, and legal requirements, requirements for informed consent and adherence to state-mandated disclosures. Contraindication review is aligned with current clinical understanding that no absolute contraindications exist; instead, risk-benefit determinations must follow individualized assessment and appropriate medical clearance. It also establishes the approach to ECT frequency, duration, maintenance, and tapering based on clinical response.

To help with oversight and keep CalOptima Health aligned with regulatory expectations, the policy ties in CalOptima Health's existing authorization and referral processes outlined in CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers and CalOptima Health Policy CC.1600: Authorization and Processing of Referrals. This helps ensure requests are handled consistently and that CalOptima Health gets the full clinical information it needs, such as symptom measurement scales, psychiatric and medical evaluations, treatment history, and a clear risk-benefit explanation.

Collectively, these elements position CalOptima Health Policy CC.1403 as a regulatory-aligned, well-supported framework that supports CalOptima Health's larger goal of ensuring members have timely access to the behavioral health care they need. It also helps CalOptima Health maintain parity, ensure consistency across member and provider materials and ensure safe and appropriate delivery of ECT services within its Covered California products.

Fiscal Impact

The recommended actions are operational in nature and have no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, rules, and accreditation standards, CalOptima Health staff recommends that the Board of Directors approve and adopt the new behavioral health policies and procedures.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy CC.1401: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
2. CalOptima Health Policy CC.1402: Transcranial Magnetic Solution (TMS)
3. CalOptima Health Policy CC.1403: Electroconvulsive Therapy

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Policy:	CC.1401
Title:	**Authorization and Monitoring of Behavioral Health Treatment (BHT) Services**
Department:	Behavioral Health Integration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	Not Applicable
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20261105BODReviewOnly

I. PURPOSE

This policy outlines how CalOptima Health shall monitor the provision of Behavioral Health Treatment (BHT) Services and the process for determining the Medical Necessity of BHT Services. It is designed to align with California Senate Bill (SB) 855, Health and Safety Code (HSC) section 1374.721, and Department of Managed Health Care (DMHC) requirements by using the most recent applicable criteria and guidelines developed by nonprofit professional associations for the relevant clinical specialty. This policy adheres to the standards established by the Council of Autism Service Providers (CASP).

II. POLICY

A. CalOptima Health shall provide and cover or arrange, as appropriate, all Medically Necessary BHT Services, to eligible Members in compliance with applicable regulatory and contractual guidance, as well as DMHC guidance.

B. BHT means professional services and treatment programs, including applied behavior analysis and Evidence-Based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

C. In alignment with DMHC All Plan Letter (APL) 25-020: Newly Enacted Statutes Impacting Health Plans, CalOptima Health shall not require a Member previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis to maintain coverage for BHT for pervasive developmental disorder or autism.

D. CalOptima Health does not prohibit or restrict a treating Provider from reevaluating an enrollee for purposes of determining the appropriate treatment. The treatment plan shall be made available to the health care service plan upon request.

1. CalOptima Health shall not discontinue or delay existing treatment while waiting for a rediagnosis to be completed.

E. The determination of whether a BHT Service is Medically Necessary for an individual Member shall be made on a case-by-case basis, taking into account the particular needs of the Member.

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F. CalOptima Health shall comply with mental health parity requirements when providing BHT Services. Treatment limitations for BHT Services may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits.

G. Criteria for BHT Services:

1. Each of the below must be met:

a. A diagnosis of Autism Spectrum Disorder based on the most recent version of the DSM or Pervasive Developmental Disorder using clinical observations or validated assessment tools, made by a licensed qualified health care provider;

b. The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the California Business & Professions Code and California HSC §1374.73; and

c. Member must be medically and physiologically stable.

i. Placement in a 24-hour acute psychiatric, residential, or stabilization environment does not systematically disqualify a Member if the primary reason for admission is behavioral crisis related to core symptoms of Autism Spectrum Disorder.

ii. Applied Behavior Analysis (ABA) services delivered within an inpatient, residential, or acute stabilization environment must adhere to a Focused ABA Treatment Model. Interventions must target distinct, high-risk maladaptive behaviors (e.g., severe self-injurious behavior, acute physical aggression) that present an immediate barrier to safe discharge.

iii. Before starting any treatment the Provider shall work with the facility for required administrative clearance, temporary clinical privileges, or security access to the ABA Provider entity.

H. Covered BHT Services must meet the following requirements:

1. Services must be provided under a treatment plan prescribed by a qualified autism service Provider and administered by one of the following individuals, per California Business & Professions Code §§4999.200-4999.202:

a. A qualified autism service Provider;

b. A qualified autism service professional supervised by the qualified autism service Provider; or

c. A qualified autism service paraprofessional supervised by a qualified autism service Provider or qualified autism service professional.

I. A BHT Service Provider shall provide and request authorization for BHT Services in accordance with this policy and CalOptima Health Policies GG.1113: Specialty Practitioner Responsibilities, GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and CC.1600: Authorization and Processing of Referrals.

J. A BHT Service Provider will document services provided during each visit or encounter pursuant to

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CalOptima Health Policy GG.1603: Medical Records Maintenance.

K. CalOptima Health does not cover the following as BHT Services:

1. Provision or coordination of respite, day care, recreational services, educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.

2. Treatment where the sole purpose is vocationally based.

3. Custodial care. For purposes of BHT Services, custodial care:

   a. Is provided primarily for maintaining the Member's or anyone else's safety;

   b. Could be provided by persons without professional skills or training; and

   c. Services that are not Evidence-Based behavioral intervention practices.

4. When no longer Medically Necessary and discharge should be initiated per The Council of Autism Service Providers (CASP) Applied Behavior Analysis Practice Guideline for the Treatment of Autism Spectrum Disorder Third Edition:

   a. The Member has achieved the desired socially significant outcomes as developed in collaboration between the Provider, the Member, and the family, and treatment is not required to maintain functioning or prevent regression;

   b. The Member's diagnosis no longer materially impacts functioning, and treatment is not required to maintain functioning or prevent regression; or

   c. The Member is no longer benefiting from services.

L. CalOptima Health shall offer Members continued access to out-of-network Providers of BHT Services (continuity of care) for up to twelve (12) months, in accordance with existing contract requirements, CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health.

M. CalOptima Health shall provide BHT Services in accordance with timely access standards, per CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access.

N. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Health Policies CC.1200: Member Appeals, and CC.1201: Member Grievance.

O. CalOptima Health shall be responsible for coordinating the provision of BHT Services with the other entities, including but not limited to Regional Center, Department of Developmental Services, and Local Education Agency (LEA) and Orange County Behavioral Health Plan (OCBHP), managed by Orange County Health Care Agency (OCHCA), to ensure CalOptima Health and the other entities are not providing duplicative services.

P. CalOptima Health shall monitor and ensure BHT Service Providers are providing BHT Services based upon an approved treatment plan that includes providing direct services as authorized in accordance with Section III of this policy.

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III. PROCEDURE

A. Prior Authorization

1. Prior Authorization requests for the Functional Behavior Assessment (FBA) shall be submitted as described in CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and CC.1600: Authorization and Processing of Referrals.

    a. A completed BHT-Authorization Request Form (BHT-ARF) is required except in cases where a BHT Provider submits through CalOptima Health's Provider portal;

    b. Include the following information related to the recommendation from the referring licensed physician/surgeon or licensed clinical psychologist:

        i. Full name and credentials of a licensed physician, surgeon, or licensed clinical psychologist who is making the recommendation;

            a) Professional making recommendations cannot be an educational psychologist or master's level clinician/practitioner (Licensed Marriage and Family Therapist, (LMFT), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselor (LPCC), Physician Assistant (PA), Nurse Practitioner (NP), etc.

            b) The recommendation and diagnosis information must be from the same physician/surgeon/clinical psychologist and all within the same document;

            c) A Medical Doctor's (MD) full name, credentials and signature are only required when a recommendation is written by a NP or PA, and in cases where there are multiple names on the document and/or unclear who made the recommendation; and

        ii. Accepted wording for the recommendation for evidenced-based BHT services: ABA, BHT, ABA therapy, ABA treatment, ABA or BHT, Behavior or Behavioral Therapy and Behavioral Analysis ABA evaluation wording is acceptable only for FBA request;

        iii. Date;

        iv. Second Identifier of Member (e.g., date of birth, address, etc.); and

        v. Signatures that can be accepted include wet, electronic, digital, or scanned.

2. Prior Authorization request for BHT treatment shall be submitted as described in CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and CC.1600: Authorization and Processing of Referrals.

    a. A completed BHT-Authorization Request Form (BHT-ARF) is required, except in cases where a BHT Provider submits through CalOptima Health's Provider portal, as listed in Section III.A.1.a.

B. The Behavioral Treatment Plan

1. The treatment plan shall be reviewed no less than once every six months by the qualified autism

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service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service Provider does all of the following:

a. Describes the patient's behavioral health impairments or developmental challenges that are to be treated.

b. Provides intervention plans that utilize Evidence-Based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

c. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

d. The treatment plan is not used for purposes of providing or for the reimbursement of respite, daycare, or educational services and is not used to reimburse a parent for participating in the treatment program.

e. The treatment plan shall be made available to the health care service plan upon request

2. Treatment plans must be signed and dated by a Qualified autism service professional per California Business & Professions Code §4999.201, which confirms that they developed, supervised, and approved the plan.

   a. Signatures that can be accepted include: wet, electronic, digital, or scanned.

3. The behavioral treatment plan must be modified or discontinued only if it is determined that the services are no longer Medically Necessary.

4. Decreasing the amount and duration of services is prohibited if the therapies are Medically Necessary.

5. The BHT Provider shall document in the behavioral treatment plan the most recent version of the standardized cognitive and adaptive testing tools including but not limited to: Vineland Adaptive Behavior Scale, Adaptive Behavior Assessment System (ABAS), Developmental Assessment of Young Children (DAYC), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) and Assessment of Basic Language and Learning Skills (ABLLS) to assess the Member's age-specific impairments.

6. The approved behavioral treatment plan must also meet the following criteria:

   a. Include a description of patient information, reason for referral, brief background information (e.g., demographics, living situation, or home/school/work information), clinical interview, review of recent assessments/reports, and assessment procedures and results, and evidence-based BHT services;

   b. Identify goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation;

   c. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;

   d. Include outcome measurement assessment criteria that will be used to measure achievement of

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behavior objectives;

e. Include the Member's current level of need (including baseline), mastery criteria, date of introduction, estimated date of mastery, generalization, and report the goal as met, not met, modified;

f. Clearly identify the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the Member's progress is measured and reported, transition plan, crisis plan, and each individual Provider who is responsible for delivering services;

g. Include care coordination that involves the parents or caregiver(s), school, state disability programs, and other programs and institutions, as applicable; and

h. Include an exit plan/criteria.

7. Coordination of Care

a. CalOptima Health shall establish data and information sharing agreements as necessary to coordinate the provision of services with other entities that may have overlapping responsibility for the provision of BHT services, including but not limited to Regional Center of Orange County (RCOC), LEAs, and Orange County Behavioral Health Plan (OCBHP) managed by the Orange County Health Care Agency (OCHCA) Behavioral Health Services (BHS), Adult and Older Adult (AOA) and Children and Youth (CYS).

b. CalOptima Health shall coordinate and assist for any medical service needs, including but not limited to Durable Medical Equipment (DME) and medication, with CalOptima Health medical Providers as applicable.

c. CalOptima Health shall document any coordination of care and communication with the Member's other medical and behavioral Providers, as applicable.

8. LEAs and BHT Services

a. School-based service requests are reviewed for medical necessity and must include any active Individualized Education Plan (IEP) or equivalent completed by the school to ensure no duplication of services being requested.

9. Monitoring and Oversight

a. BHT treatment plans are reviewed during the utilization management process. When a BHT Service Provider's behavioral treatment plan is not complete resulting in a denial, the Behavioral Health Integration (BHI) Department may refer the BHT Service Provider to the Quality Improvement Department, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue, Review Process.

b. CalOptima Health's Behavioral Health Integration (BHI) and Delegation Oversight Departments performs monthly monitoring to ensure compliance with regulation, in accordance with CalOptima Health Policies GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, CC.1700: Standards of Accessibility and Timely Access, and CC.1400: Behavioral Health Services.

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c. The BHI department reports BHT over and underutilization trends to explore and identify any further action or analysis needed to the CalOptima Health Utilization Management Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition Text Revision, Washington, DC, American Psychiatric Association, September 2025
B. Behavioral Health Treatment - Authorization Request Form (BHT-ARF)
C. California Business & Professions Code §§4999.200, 4999.201, & 4999.202
D. California Health & Safety Code §§1374.721 & 1374.73
E. California Senate Bill (SB) 855
F. CalOptima Health Policy CC.1200: Member Appeals
G. CalOptima Health Policy CC.1201: Member Grievance
H. CalOptima Health Policy CC.1400: Behavioral Health Services
I. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health
J. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals
K. CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access
L. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
M. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health
N. Direct and CalOptima Health Community Network Providers
O. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
P. CalOptima Health Policy GG.1603: Medical Records Maintenance
Q. CalOptima Health Policy GG.1611: Potential Quality Issue, Review Process
R. Council of Autism Service Providers (CASP) Applied Behavior Analysis Practice Guideline for the Treatment of Autism Spectrum Disorder Third Edition
S. Department of Managed Health Care (DMHC) All Plan Letter (APL) 25-020: Newly Enacted Statutes Impacting Health Plans
T. Welfare and Institution Code §14197 and 4686.2

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1401	Authorization and Monitoring of Behavioral Health Treatment (BHT) Services	Covered California

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IX. GLOSSARY

Term	Definition
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-TR). 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.
Behavioral Health Treatment (BHT)	Services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other Evidence-Based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member who has been diagnosed with ASD or Pervasive Developmental Disorder, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.to be delivered primarily in the home and in other community settings.
Behavioral Health Treatment (BHT) Services	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other Evidence-Based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with or without Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
Behavioral Health Treatment (BHT) Service Provider	Providers that are State Plan-approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals.
Durable Medical Equipment (DME)	Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.
Evidence-Based	A document or recommendation created using unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.
Individualized Education Plan (IEP)	A written document for an individual with exceptional needs that is developed, reviewed, and revised in a meeting in accordance with Sections 300.320 to 300.328, inclusive of Title 34 of the Code of Federal Regulations and California Education Code, Title 2, Division 4, Part 30. It also means "individualized family service plan" as described in Section 1436 of Title 20 of the United States Code if the individualized education program pertains to an individual with exceptional needs younger than three (3) years of age.
Intermediate Care Facility (ICF)	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 ICF/DD as defined in H&S section 1250(g) and does not include the ICF/DD

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Term	Definition
	3. Continuous Nursing Care Program.
Local Education Agency (LEA)	A school district, county office of education, charter school, community college district, California State University or University of California campus.
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by Health and Safety Code §1374.72 (a)(3)(A).
Medical Record	The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.
Member	A subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.
Prior Authorization	The approval process for certain services and supplies. To get a copy of CalOptima Health's Prior Authorization requirements not specified in this Evidence of Coverage call CalOptima Health Customer Service at 1-888-312-2221 (TTY 711 if you are deaf or hard of hearing).
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.

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Policy:	CC.1402
Title:	**Transcranial Magnetic Solution (TMS)**
Department:	Behavioral Health Integration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20260105BODReviewOnly

I. PURPOSE

This policy outlines the process for determining the Medical Necessity of Transcranial Magnetic Stimulation (TMS) for behavioral health conditions. It is designed to align with California Senate Bill 855 (SB 855), Health and Safety Code section 1374.721, and Department of Managed Health Care (DMHC) requirements by using the most recent applicable criteria and guidelines developed by nonprofit professional associations for the relevant clinical specialty. This policy adheres to the standards established by the Canadian Network for Mood and Anxiety Treatments (CANMAT), American Psychological Association and American Psychiatric Association.

II. POLICY

A. TMS is a noninvasive neuromodulation treatment using pulsed magnetic fields to induce electrical activity in targeted cortical regions. TMS includes repetitive TMS (rTMS), deep TMS (dTMS), and the U.S. Food and Drug Administration (FDA) cleared theta burst stimulation protocols when used within their clinically supported application. The initial course of treatment is intended to achieve clinically meaningful response or remission of an active episode of a neuropsychiatric disorder. A subsequent course or additional treatments can be used after recurrence or clinically significant worsening following a prior beneficial TMS course. In conventional TMS, high-frequency stimulation is typically applied to the left dorsolateral prefrontal cortex (DLPFC), while low-frequency stimulation is applied to the right DLPFC. Bilateral TMS uses both approaches within the same session. dTMS uses an H-coil system designed to stimulate a wider and deeper area of the brain compared with conventional coils. Theta-burst stimulation delivers short bursts of stimulation at lower intensities and shorter intervals than conventional TMS protocols.

B. The requested TMS modality and protocol should be clinically appropriate for the Member's condition and consistent with current nonprofit guidance and applicable FDA-cleared use. This may include conventional rTMS, dTMS, and intermittent Theta-burst stimulation (iTBS) when clinically appropriate.

1. iTBS shall not be denied solely because treatment sessions are shorter than conventional 10-Hz rTMS when the protocol is supported by current Clinical TMS Society (CTMSS) guidance.

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2. Protocol selection, stimulation parameters, treatment target, and modifications during the course should remain clinically driven and consistent with accepted TMS practice.

3. Requests for accelerated, individualized, or emerging protocols shall be evaluated against the most current applicable nonprofit guidance, peer-reviewed evidence, FDA status, and generally accepted standards without automatically applying criteria developed for a materially different protocol which is aligned with CalOptima Health GG.1102: Experimental & Investigational Service Coverage.

C. Frequency and Duration

1. Major Depressive Disorder (MDD): A standard course of rTMS for MDD typically involves daily sessions, five (5) days per week, with each session lasting twenty (20) to forty (40) minutes. Up to thirty (30) sessions are considered reasonable and necessary. Treatment is often followed by six (6) tapering sessions over approximately three (3) weeks. Therapeutic benefits may persist for several months.

   a. Three-times-weekly protocols appear similarly effective, though symptom improvement may occur more gradually. Accelerated approaches—delivering multiple sessions per day (2–10)—are being evaluated to shorten the overall treatment period. The FDA has cleared the SAINT protocol (Stanford Accelerated Intelligent Neuromodulation Therapy) as an accelerated TMS option for adults with treatment-resistant depression. SAINT consists of ten (10 sessions per day over five (5) days (fifty (50) total sessions).

   b. Positive response is typically fifty percent (50%) or greater improvement from baseline as measured by standardized depression scales. The American Psychiatric Association (APA) lists the Patient Health Questionnaire-9 (PHQ-9), Beck Depression Inventory-II (BDI-II), and Hamilton Rating Scale for Depression (HAM-D/HDRS). Measurement-based symptom assessment should be performed weekly or every two (2) weeks during an acute rTMS course

2. Obsessive-Compulsive Disorder (OCD): A standard course of dTMS for OCD typically involves daily sessions, five (5) days per week, with each session lasting twenty (20) to forty (40) minutes. Up to thirty (30) sessions are considered reasonable and necessary. Treatment can be extended by 1-2 weeks (5-10 sessions) if only a partial response is achieved as measured by the Yale-Brown Obsessive Compulsive Scale (Y-BOCS).

   a. Currently standard treatment approaches include Cognitive-Behavioral Therapy (CBT), specifically Exposure and Response Prevention (ERP), usually combined with serotonin-acting agents (e.g., selective serotonin reuptake inhibitors and clomipramine).

   b. Positive response is typically thirty percent (30%) or more reduction in symptoms per the Y-BOCS. A reduction between twenty percent (20%) and twenty-nine percent (29%) is labeled a partial response, and anything below twenty percent (20%) is considered a non-response.

3. The effectiveness of maintenance TMS following an acute response remains unclear. More robust evidence is required to determine long-term benefits, risks, and optimal maintenance schedules.

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4. Medical Records should document all TMS responses, including any prior treatment, subsequent symptom course, current severity/functional impact, and the clinical rationale for treatment.

D. Contraindications

1. The presence of implanted ferromagnetic or magnetically sensitive or electrical devices in the head or neck area, such as intracranial clips, electrodes, plates, stimulators, cochlear implants, metal fragments, deep brain stimulator (DBS), or MRI-unsafe implanted devices, as well as tattoos containing ferromagnetic ink.

2. If the initial TMS evaluation indicates contraindications or medical complexities, such as cardiovascular disease or a traumatic brain injury, appropriate evidence of additional medical clearance may be required before starting treatment. This can be done by medical professionals, including neurologists, cardiologists, or primary care physicians.

E. Medication: Adequate Dose and Duration

1. An adequate medication trial typically consists of at least four (4) to six (6) weeks at recognized therapeutic dosing levels. A shorter trial may be clinically indicated if a specific safety issue is present including significant adverse effects, intolerance, or a medical contraindication.

F. Adequate Trial of Psychotherapy

1. A sufficient psychotherapy trial generally includes at least eight (8) weekly sessions of an evidence-based treatment the diagnosis during the current episode. If the psychotherapy trial is less than at least eight (8) weekly sessions, the Medical Record must document reason(s) for discontinuation.

III. PROCEDURE

A. Prior Authorization

1. Requests for TMS shall be submitted as described in CalOptima Health Policies GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers and CC.1600: Authorization and Processing of Referrals .

2. A completed Behavioral Health-Authorization Request Form (BH-ARF) is required except in cases where a BH Provider submits through CalOptima Health's Provider portal.

B. TMS may be considered Medically Necessary for MDD when all of the following have been met:

1. Diagnosis of MDD/Treatment-Resistant Depression (TRD), (single or recurrent) from the most recent Diagnostic and Statistical Manual of Mental Disorders (DSM).

2. Age: 15 years to 86 years

3. With at least one (1) of the following:

a. TRD as supported by one (1) or more of the following:

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i. Inadequate response (less than fifty perfect (50%) reduction in symptoms from baseline) to two (2) antidepressant medications at a therapeutic dose and adequate duration

ii. Inadequate response (less than fifty perfect (50%) reduction in symptoms from baseline) to one (1) antidepressant medication plus one (1) adjunctive medication at a therapeutic dose and adequate duration.

4. Tolerability concerns with medication options

a. History of a positive response to TMS in a previous depressive episode.

5. Using an FDA-cleared device and modality for the diagnosis.

C. TMS may be considered Medically Necessary for OCD when all of the following conditions have been met:

1. Diagnosis of OCD/treatment-resistant OCD from the most recent DSM

2. Age: 22 years to 68 years

3. With at least one (1) of the following:

a. Treatment-resistant OCD is supported by evidence of inadequate response to first-line treatment of Cognitive Behavioral Therapy (CBT), specifically Exposure and Response Prevention (ERP) and 1 trial of Selective Serotonin Reuptake Inhibitors (SSRIs) for eight to twelve (8-12) weeks with less than thirty-five (35%) reduction in symptoms from baseline.

b. Tolerability concerns with medication options.

c. History of a positive response to TMS in a previous episode.

4. Using an FDA-cleared device and modality for the diagnosis

D. TMS may be considered Medically Necessary for Tobacco Use Disorder when all of the following conditions have been met:

1. Diagnosis of Tobacco Use Disorder from the most recent version of the DSM

2. Ages: 22 years-70 years

3. Treatment resistance, defined as inadequate response after at least two (2) traditional cessation attempts, including but not limited to nicotine replacement therapies, varenicline, or structured psychotherapy.

4. Using the FDA-cleared device dTMS H4 coil

E. The non-profit guidance recognizes maintenance TMS as a strategy for relapse prevention. However, the guidance does not provide a single standardized maintenance schedule, and guidelines vary based on differences in evidence classification. Any maintenance TMS requests will be reviewed as investigational per CalOptima Health Policy GG.1102: Experimental & Investigational Service Coverage.

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F. The non-profit guidance recognizes maintenance TMS as a strategy for relapse prevention. However, the guidance does not provide a single standardized maintenance schedule, and guidelines vary based on differences in evidence classification. Any maintenance TMS requests will be reviewed as investigational per CalOptima Health Policy GG.1102: Experimental & Investigational Service Coverage.

G. All TMS requests should include supporting documentation, including but not limited to:

1. Reason(s) for treatment.

2. Confirmation of treatment resistance.

   a. Include standardized rating scale(s) used with date completed and score that indicates moderate or higher.

      i. MDD: score of 15 or above on the PHQ-9, score of 30 or above on the BDI-II, or a score of 20 or above on the HAM-D/ HDRS.

      ii. OCD: score of 20 or above on the Y-BOCS.

      iii. Smoking Cessation: formal diagnosis of Tobacco Use Disorder per the most recent DSM criteria.

3. Current medications, including dosages, start/end date, and response.

4. Description of medication trials, including augmentation during current episode, dose, start/end dates, and response including any documentation of tolerability concerns.

5. Psychotherapy trials during current episode. Include modality, frequency, start/end dates, and response.

6. Previous TMS treatment, including the number of sessions, start/end dates, modality and response (including first and last standardized rating scale).

7. Confirmation of no contraindications or description of any contraindications that occurred with documented medical clearance and plan of action.

8. Type and regimen/protocol of TMS planned for use.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. American Psychological Association. FDA clears transcranial magnetic stimulation (TMS) for youth, and a shorter version for adults. Accessed April 11, 2026
B. American Psychological Association. (2026, July 1). What's new, what's next: Using brain stimulation to treat mental illness. *Monitor on Psychology*, *57*(5)
C. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals
D. CalOptima Health Policy GG.1102: Experimental & Investigational Service Coverage.

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E. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
F. California Health and Safety Code § 1374.721. Mental health and substance use disorder utilization review requirements
G. Canadian Psychiatric Association. (2023). Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults. The Canadian Journal of Psychiatry 2024, Vol. 69(9), 641-687.
H. Clinical TMS Society. Coverage Guidance for Transcranial Magnetic Stimulation (TMS) for Major Depressive Disorder (MDD). Approved August 25, 2025.
I. Clinical TMS Society. (2024, August). *Coverage guidance for TMS for smoking cessation*
J. Department of Managed Health Care (DMHC) All Plan Letter (APL) 21-002: Implementation of SB 855, Mental Health (MH)/Substance Use Disorder (SUD) Coverage, including Attachment A, as updated or superseded.
K. Department of Managed Health Care (DMHC) All Plan Letter (APL) 24-007: Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage (04/03/2024)
L. Richard A. Bermudes., Karl Lanocha., & Philip G. Janicak (2024). *Transcranial Magnetic Stimulation*. American Psychiatric Association Publishing.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1402	Transcranial Magnetic Solution (TMS)	Covered California

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IX. GLOSSARY

Term	Definition
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For Medically Necessary Treatment of a mental health or substance use disorder, Medical Necessity shall include a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by Health and Safety Code §1374.72 (a)(3)(A).
Medical Record	The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.
Member	A subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.

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Policy:	CC.1403
Title:	**Electroconvulsive Therapy**
Department:	Behavioral Health Integration
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy outlines the process for determining the medical necessity of electroconvulsive therapy (ECT) for behavioral health conditions. It is designed to support compliance with California Senate Bill 855 (SB 855) and Health and Safety Code section 1374.721, Department of Managed Health Care (DMHC) requirements by using the most recent applicable criteria and guidelines developed by the nonprofit professional associations for the relevant clinical specialty. This policy adheres to the standards established by the Canadian Network for Mood and Anxiety Treatments (CANMAT), American Psychological Association and American Psychiatric Association and American Academy for Child and Adolescent Psychiatry (AACAP).

II. POLICY

A. ECT is an established medical procedure used primarily for the treatment of severe major depressive disorder (MDD) and catatonia. It may also be indicated for other behavioral health conditions when clinically appropriate. During ECT, a controlled electrical stimulus is administered to the brain while the individual is under general anesthesia. This stimulus induces a brief, medically supervised seizure involving the entire brain. The resulting neurophysiologic changes can lead to improvement in symptoms associated with severe depression, catatonia, and other treatment-resistant conditions.

B. For individuals under age 18, both clinical guidance and California-specific laws help determine whether ECT may be appropriate and covered. Nonprofit associations including the APA and AACAP support access for minors when clinically indicated and emphasize individualized assessment. In California, additional requirements around consent, capacity, custody, and possible court involvement may apply, and situations involving these factors may warrant Legal or Compliance review.

C. Providers must be in compliance with California regulatory standards by obtaining valid, uncoerced informed consent. The Provider must ensure the Member meets all state-mandated disclosure and capacity requirements before any ECT session is initiated.

D. Frequency and Duration

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1. Current APA guidance describes Acute Phase ECT as commonly administered two or three times per week on alternating days. The number of treatments shall be driven by clinical response and tolerability. When remission or a plateau of improvement is reached, ECT should be tapered.

2. Maintenance Phase ECT is usually started on a weekly basis, with the interval between treatments gradually extended to a month, depending on the clinical response.

3. Frequency may be modified based on clinical urgency, response, cognitive or other adverse effects, and individual circumstances.

4. Requests extending beyond an initially authorized course should include updated clinical information sufficient to evaluate response, adverse effects, and the rationale for additional treatment.

E. Contraindications

1. ECT has no universally recognized absolute contraindications. Certain medical, neurological, cardiovascular, or anesthesia-related conditions may increase treatment risk and require individualized clinical assessment, appropriate medical clearance, and/or additional precautions.

2. The presence of such a condition does not establish that ECT is medically unnecessary or contraindicated; treatment decisions should be based on an individualized risk-benefit assessment consistent with generally accepted standards of care.

III. PROCEDURE

A. Prior Authorization

1. Requests for ECT shall be submitted as described in CalOptima Health Policies, GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and CC.1600: Authorization and Processing of Referrals.

2. A completed Behavioral Health-Authorization Request Form (BH-ARF) is required except in cases where a BH Provider submits through CalOptima Health's Provider portal.

B. ECT may be considered Medically Necessary when all the following conditions are satisfied:

1. Age requirement:

a. The individual is at least thirteen (13) years of age or older.

2. Clinical condition requirement where the individual has at least one (1) qualifying condition:

a. Primary indications:

i. Severe/life threatening depression requiring rapid response (i.e. major depression with acute high suicide risk)

ii. Depression with psychotic features

iii. Catatonia

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iv. Food or fluid refusal with resulting dehydration/malnutrition, or rapidly deteriorating physical status from self-neglect

v. Prior positive response to ECT

vi. Severe depression in pregnancy

a. Second line indications:

i. Treatment-resistant major depression

ii. Bipolar disorder

a) Treatment-refractory bipolar depression

b) Acute manic episodes

c) Refractory mixed episodes

iii. Schizophrenia

a) Treatment-resistant schizophrenia

iv. Other:

a) Neuroleptic Malignant Syndrome

v. Psychosis

3. Treatment-related considerations where at least one (1) or more of the following applies:

a. Previous medication trials have not produced adequate improvement;

b. The individual cannot tolerate necessary psychiatric medications;

c. Psychiatric symptoms and impairments are worsening;

d. Suicidal ideas or behaviors are present;

e. The clinical situation is urgent, and a therapeutic response is needed;

f. The individual has responded well to ECT in the past; and/or

g. A risk-benefit review supports choosing ECT instead of other available treatments.

4. Evaluation requirement:

a. A complete ECT assessment has been performed, including both medical and psychiatric evaluations.

C. Continuation and maintenance ECT may be considered Medically Necessary when one or more of the following criteria are met:

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1. The Member demonstrates meaningful clinical benefit from ECT, based on standardized rating scale corresponding to the diagnosis. Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI-II), Hamilton Depression Rating Scale (HAM-D/HDRS), Young Mania Rating Scale (YMRS) for manic episodes and the Bush-Francis Catatonia Rating Scale (BFCRS) for catatonia showing a fifty percent (50%) or greater reduction from pre-treatment baseline for the relevant diagnosis and continued treatment is clinically indicated to consolidate response or reduce relapse or recurrence.

2. The Member requires rapid reduction of acute symptoms, including but not limited to: imminent risk of self-harm, reversal of severe food or fluid refusal that threatens medical safety, or resolution of severe catatonia and continued treatment is clinically indicated to consolidate response or reduce relapse or recurrence.

3. There is documented partial response showing a reduction between twenty-five to forty-nine percent (25%-49%) from pretreatment baseline for the relevant diagnosis including completion dates and scores based on standardized rating scales (PHQ-9, BDI-II, HAM-D/HDRS, YMRS and BFCRS).

D. Tapering should occur when no further meaningful clinical improvement has been observed across two consecutive treatments within the same course.

E. All ECT requests should include supporting documentation (e.g. History and Physical (H&P), psychiatric evaluation, or consultation notes, including but not limited to:

1. Clinical Presentation: Description of current psychiatric symptoms, duration, comorbidities, and associated activity/functional limitations.

2. Objective Measurement: Baseline or current standardized clinical rating scale scores at minimum from one (1) of the listed standardized rating scales that are corresponding to the diagnosis: PHQ-9, BDI-II, HAM-D/HDRS, YMRS and BFCRS.

3. Comprehensive Treatment History:

   a. Detailed history of all attempted psychiatric medications and modalities, specifying exact doses, treatment duration, adherence, and clinical response.

   b. Any history of prior ECT courses, including completion dates and previous therapeutic response.

4. Clinical Rationale & Plan: Clear documentation of the reason for the procedure (including any emergency triggers), a structured treatment plan, and the risk-benefit rationale.

5. Medical Clearances: Complete pre-ECT consultation reports and formal medical/anesthesia clearance documentation.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. American Academy of Child and Adolescent Psychiatry. Practice parameter for use of electroconvulsive therapy with adolescents. *Journal of the American Academy of Child Adolescent Psychiatry (JAACAP)*. 2004;43(12):1521-1539. doi:10.1097/01.chi.0000142277.81363.ad

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B. American Psychiatric Association. (2025). The practice of electroconvulsive therapy: Recommendations for treatment, training, and privileging (A Task Force Report of the American Psychiatric Association) (3rd ed.). American Psychiatric Pub. ISBN 978-0-89042-712-5.
C. California Department of Managed Health Care (DMHC) All Plan Letter (APL) 21-002, SB 855, Mental Health and Substance Use Disorder Coverage, including Attachment A, as updated or superseded.
D. California Department of Managed Health Care (DMHC) All Plan Letter (APL) 24-007, Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage. April 3, 2024.
E. California Health and Safety Code § 1374.721. Mental health and substance use disorder utilization review requirements
F. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals
G. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
H. Canadian Psychiatric Association, Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults. The Canadian Journal of Psychiatry 2024, Vol. 69(9), 641-687.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective		CC.1403	Electroconvulsive Therapy	Covered California

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IX. GLOSSARY

Term	Definition
Medically Necessary	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For Medically Necessary Treatment of a mental health or substance use disorder, Medical Necessity shall include a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care Provider, as required by Health and Safety Code §1374.72 (a)(3)(A).
Member	A subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action to be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

13. Adopt Resolution No. 26-1105-01 Approving the Proposed 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; 2027 CalOptima Health Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Program; and Revised Office of Compliance Policies and Procedures

Contact

John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Action

Adopt Resolution No. 26-1105-01 approving:

a. Proposed 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan; and 2027 CalOptima Health HIPAA Privacy and Security Program; and

b. Revised CalOptima Health Office of Compliance Policies and Procedures:

HH.3001	Member Access to Designated Record Set
HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)
HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII, or Other Unauthorized Use or Disclosure of PHI/PII
HH.3023	Information Sharing
HH.4003	Annual Risk Assessment (Internal)
HH.4004	Grant Audits/Reviews

Background

CalOptima Health is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including federal and state health care program requirements. As part of that commitment, the CalOptima Health Board of Directors (Board) is annually presented with CalOptima Health's Compliance Program and associated documents (Compliance Program) for review and approval. The 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan; and 2027 CalOptima Health HIPAA Privacy and Security Program, comprehensively address the fundamental elements necessary for an effective Compliance Program, including those elements identified by the Office of Inspector General

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(OIG) of the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS).

Compliance Program Elements
Federal laws and regulations (including the CMS Medicare Advantage regulations) and OIG compliance guidance require that compliance programs be reasonably designed, implemented, and enforced to ensure the programs are effective in preventing, detecting, and correcting violations of standards or law. CalOptima Health's Compliance Program addresses each of the seven fundamental elements of an effective Compliance Program, in addition to FWA prevention, detection, and remediation.

Written Standards
As part of its Compliance Program, CalOptima Health develops, maintains, and distributes to its Board, employees, and first tier, downstream, or related entities (FDRs) written standards in the form of the 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan; and the 2027 CalOptima Health HIPAA Privacy and Security Program, and written policies and procedures, as further detailed in the proposed 2027 CalOptima Health Compliance Plan. The 2027 CalOptima Health Compliance Plan incorporates all the elements of an effective compliance program, as recommended by the OIG and required by CMS regulations. The Compliance Program also includes a comprehensive Anti-FWA Plan, which establishes guidelines and procedures designed to prevent, detect, and remediate FWA in CalOptima Health programs.

Oversight
As CalOptima Health's governing body, the Board is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the Chief Executive Officer, who then delegates to the Chief Compliance Officer, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Chief Compliance Officer, in conjunction with the Compliance Committee, is accountable for the oversight and reporting roles and responsibilities set forth in the 2027 CalOptima Health Compliance Plan. The Delegation Oversight Committee, a subcommittee of the Compliance Committee, is responsible for overseeing delegated activities.

Training and Education
Utilizing web-based courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and education regarding CalOptima Health's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles within CalOptima Health's departments and programs. Upon appointment, hire, or commencement of a contract, and annually thereafter, the Board, employees, and FDRs receive CalOptima Health's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, including FWA (where applicable), Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, Health Information Technology for Economic and Clinical

Health (HITECH) Act requirements, and the Confidentiality of Medical Information Act (CMIA) compliance.

Effective Lines of Communication and Reporting
CalOptima Health utilizes various methods to communicate general information, regulatory updates, and process changes from the Chief Compliance Officer to the Board, employees, FDRs, and Members, including, but not limited to, presentations at meetings and updates in print and/or electronic form about how to identify, report, and prevent compliance issues and FWA. The Board, employees, FDRs, and/or members receive information and reminders to report compliance concerns, questionable conduct or practices, suspected or actual non-compliance issues, and FWA incidents through one of CalOptima Health's multiple reporting mechanisms. These reporting options provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima Health maintains and supports a non-retaliation policy governing good-faith reports of suspected or actual non-compliance and/or FWA.

Enforcement and Disciplinary Standards
The Board, employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima Health's standards, requirements, or applicable laws, as specified in the Compliance Program documents and related policies and procedures, including, but not limited to, CalOptima Health's policies and procedures on performance and behavior standards, corrective action plans, and/or sanctions. CalOptima Health implements consistent, timely, and effective enforcement of standards when non-compliance or unethical behavior is determined, including any appropriate disciplinary action to address improper conduct, activity, and/or behavior.

Monitoring, Auditing, and Identification of Risks
CalOptima Health has implemented and continues to implement comprehensive monitoring and auditing activities, which are performed by the Delegation Oversight Department and Internal Audit Department in conjunction with CalOptima Health contract owners and functional business owners responsible for ongoing monitoring. The purpose of CalOptima Health's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and federal and state laws, as well as applicable policies and procedures established to protect against non-compliance and potential FWA in CalOptima Health's programs. The 2027 CalOptima Health Compliance Plan and related policies and procedures address the monitoring and auditing processes carried out by CalOptima Health.

Response and Remediation
Once a violation or offense has been detected or reported, CalOptima Health initiates all necessary steps to investigate, identify, and respond appropriately to the violation or offense and to prevent similar violations and offenses from occurring. As described in the 2027 CalOptima Health Compliance Plan, CalOptima Health will conduct a timely and documented investigation and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and policies and procedures, to prevent the same or similar violation or offense from occurring in the future.

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Discussion

CalOptima Health regularly reviews its Compliance Plan, Code of Conduct, Anti-Fraud, Waste, & Abuse (FWA) Plan, and CalOptima Health HIPAA Privacy and Security Program to ensure current alignment with federal and state health care program requirements and laws as well as CalOptima Health operations. CalOptima Health's Chief Compliance Officer has reviewed the proposed 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, & Abuse (FWA) Plan; 2027 CalOptima Health HIPAA Privacy and Security Program and revised Office of Compliance policies and procedures to ensure consistency with applicable federal and state health care program laws, regulations, and/or guidance.

Summary of Changes

The 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan; and 2027 CalOptima Health HIPAA Privacy and Security Program have been updated and revised as follows:

- The Proposed **2027 CalOptima Health Compliance Plan** was revised to integrate internal surveys, reviews, and strategic areas of interest identified by CalOptima Health leaders and stakeholders into the risk assessment operations and processes used for evaluation. Staff also incorporated Covered California into the applicable CalOptima Health programs included in the Compliance Plan.

- The Proposed **2027 CalOptima Health Code of Conduct** content remains unchanged from the 2026 CalOptima Health Code of Conduct approved version.

- The Proposed **2027 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan** was revised to add a minor grammatical edit to include OneCare to its glossary terminology.

- The Proposed **2027 CalOptima Health HIPAA Privacy and Security Program** was updated to add information regarding the attestation requirements and oversight responsibilities for offshore subcontractors that access, use, store, process, or transmit protected health information, personally identifiable information, or other confidential information.

Policies and Procedures

Consistent with applicable federal and state health care program laws, regulations and/or guidance, the Chief Compliance Officer, with the support of the Office of Compliance staff, has updated the related policies and procedures. The summary of changes is included in Attachment 6. This summary contains a list of policies with substantive changes that are reflected in the policies and procedures in Attachment 7. The revised policies and procedures also reflect non-substantive changes (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Fiscal Impact

The recommended actions to approve the proposed 2027 CalOptima Health Compliance Plan, 2027 CalOptima Health Code of Conduct, 2027 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan, 2027 CalOptima Health HIPAA Privacy and Security Program, and revised Office of Compliance policies and procedures have no anticipated fiscal impact. If there is any fiscal impact from increases in Compliance Program resources, it will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima Health staff recommends that the Board adopt the resolution approving and adopting the proposed 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, & Abuse (FWA) Plan; 2027 CalOptima Health HIPAA Privacy and Security Program; and related Office of Compliance policies and procedures. These documents will supersede the 2026 CalOptima Health Compliance Plan; 2026 CalOptima Health Code of Conduct; 2026 CalOptima Health Anti-Fraud, Waste, and Abuse (FWA) Plan; and 2026 CalOptima Health HIPAA Privacy and Security Program, as approved on November 6, 2025.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 26-1105-01, Resolution Approving the Proposed 2027 CalOptima Health Compliance Plan; 2027 CalOptima Health Code of Conduct; 2027 CalOptima Health Anti-Fraud, Waste, & Abuse Plan; 2027 CalOptima Health HIPAA Privacy and Security Program; and revised Policies and Procedures
2. 2027 CalOptima Health Compliance Plan
3. 2027 CalOptima Health Code of Conduct
4. 2027 CalOptima Health Anti-Fraud, Waste, & Abuse Plan
5. 2027 CalOptima Health HIPAA Privacy and Security Program
6. Summary of Proposed Actions to CalOptima Health Office of Compliance Policies and Procedures
7. Revised Office of Compliance Policies and Procedures

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RESOLUTION NUMBER 26-1105-01

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima Health

APPROVING THE 2027 CALOPTIMA HEALTH COMPLIANCE PLAN, 2027 CALOPTIMA HEALTH CODE OF CONDUCT, 2027 CALOPTIMA HEALTH ANTI-FRAUD, WASTE AND ABUSE (FWA) PLAN, 2027 CALOPTIMA HEALTH HIPAA PRIVACY AND SECURITY PROGRAM AND REVISED OFFICE OF COMPLIANCE POLICIES AND PROCEDURES

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima Health, provides that the Board of Directors is the governing body of CalOptima Health, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima Health shall be exercised, its property controlled, and its business and affairs conducted by or under the direction of the Board of Directors; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima Health's operations consistent with all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima Health's commitment to compliant, lawful, and ethical conduct, and values the importance of compliance and ethics in CalOptima Health's operations; and

WHEREAS, the Board of Directors last reviewed and approved the CalOptima Health Compliance Program on November 06, 2025, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste, and Abuse (FWA) Plan, and related Office of Compliance policies and procedures; and

WHEREAS, the Board of Directors reviews the CalOptima Health Compliance Program documents on a periodic basis to ensure the CalOptima Health Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Directors' commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2027 CalOptima Health Compliance Plan, 2027 CalOptima Health Code of Conduct, 2027 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan and the 2027 CalOptima Health HIPAA Privacy and Security Program.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance policies and procedures.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the 2027 CalOptima Health Compliance Plan, 2027 CalOptima Health Code of Conduct, 2027 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan and the 2027 CalOptima Health HIPAA Privacy and Security Program.

Section 4. These actions are effective upon the date of adoption of this Resolution.

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APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima Health, this 5th day of November 2026.

AYES:
NOES:
ABSENT:
ABSTAIN:

_____
Title: Chair, Board of Directors
Printed Name and Title: Vicente Sarmiento, Chair, CalOptima Health Board of Directors

Attest:

_____
Tina Knapp, Clerk of the Board

Orange County Health Authority
dba CalOptima Health

~~2026~~ 2027 Compliance Plan

(Revised September 202~~5~~6)

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Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

CalOptima Health - A Public Agency
505 City Parkway West | Orange, CA 92868 | www.CalOptimaHealth.org
Main: 714-246-8400 | TTY: 711

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Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Covered California, Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD) (OneCare), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date Policies and Procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, Contractor, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact the Office of Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation. You can choose to report anonymously and no identifying information will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as the framework for compliance in your work at or with CalOptima Health.

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THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Covered California, Medi-Cal, OneCare~~MAPD~~, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Covered California, Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. **Code of Conduct, Written Policies and Procedures**
2. **Compliance Officer, Compliance Committee, High-Level Oversight**
3. **Effective Training and Education**
4. **Effective Lines of Communication**
5. **Well-Publicized Disciplinary Standards**
6. **Effective System for Routine Monitoring. Auditing and Identification of Compliance Risks**
7. **Procedures and Systems for Prompt Response to Compliance Issues**

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk, but not less than annually. CalOptima Health makes this Compliance Plan available to the Board, employees, contractors, and FDRs. All Board Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

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Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to Board Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven (7) days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/about-us/transparency/compliance*. The Code of Conduct is approved by the Board and distributed to Board Members, employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Board, employees, contractors, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima Health's commitment to preventing FWA, and setting forth guidelines and

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procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. This Compliance Plan allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance.

The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her designee, will ensure that Board Members, employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, regularly reviews, and approves proposed changes to CalOptima Health's Policies and Procedures. Board Members, employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available to Board Members, employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The Board, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an employee of CalOptima Health, who handles compliance oversight and activities full-time. The Chief Compliance Officer, in

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conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation. The Board reviews and approves the Compliance Plan, Code of Conduct and Compliance Policies and Procedures annually.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board and is Chair of the Compliance Committee. In this capacity the Chief Compliance officer reports on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to escalate issues of concern directly to the Board and acts independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the Board, CEO, CalOptima Health's executive staff and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Covered California, Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board.
- Maintain and update the Compliance Plan, on an annual basis, consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board

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- ► Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).
- ► Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- ► Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.
- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- ► Review and address reports of monitoring and auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Adherence to the Compliance Program requirements, including training requirements, shall be a condition of employment and a factor in the annual performance evaluation of each Employee.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs. Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Covered California, Medi-Cal and Medicare Advantage Part D members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets,

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attestations, or electronic certifications, as required by law. The Chief Compliance Officer, CalOptima Health executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, employees, contractors, and FDRs complete training on an annual basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and updates courses regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of regulatory requirements and reinforcement of company expectations for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven (7) days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- Website: caloptima.org
- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

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b. Report Directly to Management and Executive Staff

CalOptima Health employees are encouraged to contact their immediate management or executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive staff or management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her management or executive staff did not adequately address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's Policies and Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

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a. Conduct Subject to Enforcement and Discipline

Board Members, employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA Privacy and Security Program and policies, including actions that harm the privacy of members, or the CalOptima Health information systems that store member data.

b. Enforcement and Discipline

CalOptima Health maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima Health. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, employees and contractors are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima Health to civil, criminal, or administrative sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Health employees shall be evaluated annually based on their compliance with CalOptima Health's Compliance Program. Where appropriate, CalOptima Health shall promptly initiate education and training to correct identified problems, or behaviors.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

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Monitoring and Auditing can help prevent, detect, and correct non-compliance with applicable federal and/or state requirements. A risk assessment serves as a tool for determining levels of risk and serves as a guide for which monitoring and auditing activities are performed to assess ongoing levels of compliance.

Routine Monitoring and Auditing of CalOptima Health Operations

The routine monitoring and auditing of CalOptima Health's operations is conducted by the Internal Audit Department under the Office of Compliance.

a. Risk Assessment

A Compliance Risk Assessment will be performed no less than annually to evaluate the current status of CalOptima Health's operational areas.

Operations and processes will be evaluated based on:

1) Deficiencies found by regulatory agencies
2) Deficiencies found by internal and external audit and monitoring reports
3) Institution of new or updated Policies and Procedures and/or regulations/guidance.
4) Cross departmental interdependencies
5) Significant management or organizational changes and/or significant systems changes
6) The OIG Work Plan
7) Monitoring dashboard trends
8) Internal surveys and reviews
9) Strategic areas of interest by CalOptima Health leaders and stakeholders
~~7)~~

The Director of the Internal Audit Department, or his/her designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the Director of the Internal Audit Department, or his/her designee, and presented to the Compliance Committee for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit scopes and methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

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The Internal Audit Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track performance compliance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The Internal Audit Department performs audits -based on the AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee and the Board.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual Risk Assessment

The Director of the Delegation Oversight Department, or his/her designee will conduct an annual comprehensive risk assessment to determine an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed a high risk or vulnerable, is presented to the Chief Compliance Officer to collaborate in determining appropriate follow-up. FDRs determined to be high-risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Delegation Oversight Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track compliant performance of FDRs' case management,

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credentialing, claims, and utilization management. Delegation Oversight performs audits as per the FDR AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

e. Regular Exclusion and Preclusion Screening

CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, employees, contractors, Providers, and FDRs are required to disclose their participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Chief Compliance Officer and/or Director of FWA, in conjunction with the Office of Compliance, FWA Department and other key staff, are responsible for reviewing cases of non-compliance and suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a

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frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is completed, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive staff and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Covered California, Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Covered California Program requirements to Covered California, the Department of Managed Health Care (DMHC), Medi-Cal Program requirements to California Department of Health Care Services (DHCS)~~DHCS~~ Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), the Centers for Medicare & Medicaid Services (CMS) and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

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FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer in conjunction with the Director, FWA or his/her designee, in conjunction with other compliance activities. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the Board, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by CalOptima Health Programs are appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

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Orange County Health Authority
dba CalOptima Health

2027 Compliance Plan

(Revised September 2026)

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Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Covered California, Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD) (OneCare), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date Policies and Procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, Contractor, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact the Office of Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation. You can choose to report anonymously and no identifying information will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as the framework for compliance in your work at or with CalOptima Health.

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THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Covered California, Medi-Cal, OneCare, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Covered California, Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. **Code of Conduct, Written Policies and Procedures**
2. **Compliance Officer, Compliance Committee, High-Level Oversight**
3. **Effective Training and Education**
4. **Effective Lines of Communication**
5. **Well-Publicized Disciplinary Standards**
6. **Effective System for Routine Monitoring. Auditing and Identification of Compliance Risks**
7. **Procedures and Systems for Prompt Response to Compliance Issues**

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk, but not less than annually. CalOptima Health makes this Compliance Plan available to the Board, employees, contractors, and FDRs. All Board Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

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Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to Board Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven (7) days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/about-us/transparency/compliance*. The Code of Conduct is approved by the Board and distributed to Board Members, employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Board, employees, contractors, and FDRs. This Compliance Plan also includes a comprehensive section articulating CalOptima Health's commitment to preventing FWA, and setting forth guidelines and

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procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. This Compliance Plan allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance.

The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her designee, will ensure that Board Members, employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, regularly reviews, and approves proposed changes to CalOptima Health's Policies and Procedures. Board Members, employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available to Board Members, employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The Board, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an employee of CalOptima Health, who handles compliance oversight and activities full-time. The Chief Compliance Officer, in

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conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation. The Board reviews and approves the Compliance Plan, Code of Conduct and Compliance Policies and Procedures annually.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board and is Chair of the Compliance Committee. In this capacity the Chief Compliance officer reports on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to escalate issues of concern directly to the Board and acts independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the Board, CEO, CalOptima Health's executive staff and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Covered California, Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board.
- Maintain and update the Compliance Plan, on an annual basis, consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board

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- ► Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).
- ► Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- ► Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.
- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- ► Review and address reports of monitoring and auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Adherence to the Compliance Program requirements, including training requirements, shall be a condition of employment and a factor in the annual performance evaluation of each Employee.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs. Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Covered California, Medi-Cal and Medicare Advantage Part D members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets,

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attestations, or electronic certifications, as required by law. The Chief Compliance Officer, CalOptima Health executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, employees, contractors, and FDRs complete training on an annual basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and updates courses regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of regulatory requirements and reinforcement of company expectations for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven (7) days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- Website: caloptima.org
- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

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b. Report Directly to Management and Executive Staff

CalOptima Health employees are encouraged to contact their immediate management or executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive staff or management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her management or executive staff did not adequately address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's Policies and Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

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a. Conduct Subject to Enforcement and Discipline

Board Members, employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA Privacy and Security Program and policies, including actions that harm the privacy of members, or the CalOptima Health information systems that store member data.

b. Enforcement and Discipline

CalOptima Health maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima Health. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, employees and contractors are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima Health to civil, criminal, or administrative sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Health employees shall be evaluated annually based on their compliance with CalOptima Health's Compliance Program. Where appropriate, CalOptima Health shall promptly initiate education and training to correct identified problems, or behaviors.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

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Monitoring and Auditing can help prevent, detect, and correct non-compliance with applicable federal and/or state requirements. A risk assessment serves as a tool for determining levels of risk and serves as a guide for which monitoring and auditing activities are performed to assess ongoing levels of compliance.

Routine Monitoring and Auditing of CalOptima Health Operations

The routine monitoring and auditing of CalOptima Health's operations is conducted by the Internal Audit Department under the Office of Compliance.

a. Risk Assessment

A Compliance Risk Assessment will be performed no less than annually to evaluate the current status of CalOptima Health's operational areas.

Operations and processes will be evaluated based on:

1) Deficiencies found by regulatory agencies
2) Deficiencies found by internal and external audit and monitoring reports
3) Institution of new or updated Policies and Procedures and/or regulations/guidance.
4) Cross departmental interdependencies
5) Significant management or organizational changes and/or significant systems changes
6) The OIG Work Plan
7) Monitoring dashboard trends
8) Internal surveys and reviews
9) Strategic areas of interest by CalOptima Health leaders and stakeholders

The Director of the Internal Audit Department, or his/her designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the Director of the Internal Audit Department, or his/her designee, and presented to the Compliance Committee for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit scopes and methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

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The Internal Audit Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track performance compliance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The Internal Audit Department performs audits based on the AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee and the Board.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual Risk Assessment

The Director of the Delegation Oversight Department, or his/her designee will conduct an annual comprehensive risk assessment to determine an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed a high risk or vulnerable, is presented to the Chief Compliance Officer to collaborate in determining appropriate follow-up. FDRs determined to be high-risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Delegation Oversight Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track compliant performance of FDRs' case management,

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credentialing, claims, and utilization management. Delegation Oversight performs audits as per the FDR AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

e. Regular Exclusion and Preclusion Screening

CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, employees, contractors, Providers, and FDRs are required to disclose their participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Chief Compliance Officer and/or Director of FWA, in conjunction with the Office of Compliance, FWA Department and other key staff, are responsible for reviewing cases of non-compliance and suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a

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frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is completed, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive staff and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Covered California, Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Covered California Program requirements to Covered California, the Department of Managed Health Care (DMHC), Medi-Cal Program requirements to California Department of Health Care Services (DHCS) Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), the Centers for Medicare & Medicaid Services (CMS) and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

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FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer in conjunction with the Director, FWA or his/her designee, in conjunction with other compliance activities. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the Board, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by CalOptima Health Programs are appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

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CalOptima Health

2027

CALOPTIMA HEALTH

CODE OF CONDUCT

For 20261105 BOD Review Only

Revised September 2026

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer



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Message from Chief Compliance Officer



John Tanner
CCO

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions. CalOptima Health expects all employees, contractors, officers, board members, network providers, subcontractors and downstream contractors act ethically and have a responsibility in ensuring compliance.

This document is a guide with 11 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at
1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

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Code of Conduct 11 Principles

1. Mission, Vision, and Values
2. Member Rights
3. Compliance with the Law and Applicable Program Requirements
4. Business Ethics
5. Conflicts of Interests
6. Public Integrity
7. Confidentiality
8. Compliance Program Reporting
9. Discrimination
10. Participation Status
11. Government Inquiries/Legal Disputes

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Principles and Standards

1 Mission, Vision, and Values

CalOptima Health is committed to its Mission, Vision, and Values.

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.

Values

CARES — Collaboration, Accountability, Respect, Excellence, Stewardship

2 Member Rights

CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

- **Access & Continuity of Care:** Follow policies ensuring member choice and coordination of services.
- **Health Equity:** Prioritize equity in all programs.
- **Cultural & Linguistic Services:** Provide appropriate communication support.
- **Disabled Member Access:** Comply with ADA Title III.
- **Emergency Treatment:** Follow EMTALA and anti-dumping laws.
- **Grievance & Appeals:** Inform members of rights and resolve complaints promptly.

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Member Choice, Access to Health Care Services, Continuity of Care

Employees and contractors must follow CalOptima Health policies, procedures, and laws regarding member choice, access to healthcare, and continuity of care. They must also coordinate medical and support services for individuals with special needs.

Health Equity

Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs.

Cultural and Linguistic Services

CalOptima Health and contractors must deliver culturally, linguistically, and sensory appropriate services to ensure members understand their diagnosis, medical history, treatment, and health education.

Disabled Member Access

CalOptima Health›s facilities must comply with Title III of the Americans with Disabilities Act of 1990, ensuring access for disabled members.

Emergency Treatment

Employees and contractors must follow all guidelines, policies, procedures, and laws related to CalOptima Health member access and emergency service payments, including EMTALA and state anti-dumping laws, prior authorization limits, and payment standards.

Grievance and Appeals Processes

CalOptima Health, its physician groups, Health Networks, and third-party administrators (TPA) must inform members of their grievance and appeal rights, including the state fair hearing process, through member handbooks and other communications according to policies and laws. Employees and contractors must promptly and fairly address, investigate, and resolve member complaints and grievances per CalOptima Health policies and applicable laws.

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3 Compliance with the Law and Applicable Program Requirements

CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.

- **Transparent Conduct:** Operate with integrity and fairness.
- **Obeying the Law:** No lying, stealing, or cheating.
- **Fraud, Waste & Abuse (FWA):** Prevent, detect, and report FWA. Training is mandatory.
- **Political Activities:** No use of CalOptima resources for political purposes.
- **Antitrust Compliance:** Avoid price-fixing, bid rigging, and unfair trade practices.

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Business Conduct Policies

CalOptima Health follows all federal and state laws, regulations, and DHCS contract standards. Employees, contractors, officers, board members, network providers, subcontractors, and downstream contractors are expected to act ethically and ensure compliance.

Obeying the Law

Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health.

Fraud, Waste, & Abuse (FWA)

CalOptima Health is committed to preventing, detecting, and reporting Fraud, Waste, and Abuse (FWA). The organization ensures Board members, employees, contractors, and FDRs receive necessary FWA training as per regulations. The Compliance Plan outlines examples of potential FWA and details employee and contractor obligations, as well as possible sanctions under federal and state laws. CalOptima Health requires that all parties avoid any conduct violating FWA laws, including anti-kickback statutes, false claims acts, and civil monetary penalty laws.

Political Activities

CalOptima Health is legally restricted in political participation. Its funds, property, and resources cannot be used for political campaigns or parties. Board members, employees, and contractors may engage in politics on their own time and expense but must not imply representation of CalOptima Health.

Anti-Trust

All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

4 Business Ethics

In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

- **Candor & Honesty:** Be truthful in all communications.
- **Financial & Data Reporting:** Ensure accuracy in all records and submissions.
- Regulatory Agencies: Engage openly and honestly.

Candor & Honesty

CalOptima Health requires candor and honesty from everyone in their duties and communications, including with the Board of Directors, supervisors, attorneys, and auditors. No one shall make false or misleading statements about CalOptima Health's products or services to any members or business partners.

Financial and Data Reporting

All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately represent the relevant facts and true nature of a transaction. CalOptima Health ensures all transactions are authorized by Management and recorded properly to maintain asset accountability. Fraudulent accounting or false reporting is against CalOptima Health's policy and may violate laws and regulations.

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Regulatory Agencies and Accrediting Bodies

CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.

5 Conflicts of Interest

Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.

- **Disclosure Required:** Report any personal or family ties to vendors, providers, grantees or any other individual or organization with whom CalOptima Health has or is considering a business relationship.

  Example: If a family member, i.e. your brother works for a vendor under consideration, disclose it to HR.
- **Policy References:** GA.8012 (Conflicts of Interest), AA.1204 (Gifts), AA.1216 (Solicitations)

Conflicts of Interest

Designated employees and contractors shall comply with the requirements of CalOptima Health Policy GA.8012: Conflicts of Interest, and applicable laws. Board members, employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations.

In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board.

CalOptima Health Policy GA.8012: Conflicts of Interest describes in detail prohibited conflicts of interest relative to your employment with CalOptima Health.

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One aspect of particular interest is any conflict related to family members. As noted in CalOptima Health Policy GA.8012: Conflicts of Interest:

- If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR.
  - » For example, if CalOptima Health is considering contracting with a vendor for which your spouse is an employee, you must disclose this in writing to HR.
- CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends.

For further specific information on Conflicts of Interest; Gifts, Honoraria, and Travel Payments; and Solicitation and Receipts of Gifts see CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. If you have any questions regarding these policies, you may reach out to the Chief Human Resources Officer or the Chief Compliance Officer.

6 Public Integrity

CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.

- **Public Records:** Comply with the California Public Records Act.
- **Use of Funds:** No gifts of public funds unless legally justified.
- **Public Meetings:** Follow the Ralph M. Brown Act.

Public Records

CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies.

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Public Funds

CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations.

Public Meetings

CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.

7 Confidentiality

Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

- **No Personal Benefit:** Do not use confidential info for personal gain.
- **Safeguard Member Info:** Comply with HIPAA, HITECH, and state laws.
- **Personnel Files:** Maintain confidentiality.
- **Proprietary Info:** Protect contractor data and provider IDs.

No Personal Benefit

Board members, employees, and contractors must not use CalOptima Health's confidential or proprietary information for personal gain or to benefit others, during or after their time with CalOptima Health.

Duty to Safeguard Member Confidential Information

CalOptima Health is committed to protecting its members' confidentiality. Board members, employees, and contractors must secure member identity, eligibility, social security, medical details, and other confidential information per applicable laws, including Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act

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(HITECH Act), California Security Breach Notification Law, California Confidentiality of Medical Information Act, and CalOptima Health policies and procedures.

Personnel Files

Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws.

Proprietary Information

Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

8 Compliance Program Reporting

Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

- **Reporting Requirements:** Promptly report violations to supervisors or the hotline.
- **Hotline:** 1-855-507-1805 (anonymous option available)
- **Disciplinary Action:** Non-compliance may lead to termination or legal penalties.
- **Training:** Mandatory for all employees and contractors.
- **Non-Retaliation:** Retaliation is prohibited. Retaliation can result in disciplinary action including termination.
- **FWA Referrals:** Coordinate with regulators as required.
- **Certification:** All personnel must certify understanding and compliance.

Reporting Requirements

In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or

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of CalOptima Health's policies and Compliance Plan.. Such reports may be made to a Supervisor, the Chief Compliance Officer or may also be made to CalOptima Health's Compliance and Ethics Hotline number below. Persons making reports to the hotline can do so on an anonymous basis.

Compliance and Ethics Hotline: 1-855-507-1805

No Personal Benefit

Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs.

Training and Education

CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees and contractors.

Non-Retaliation Policy

CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors involved in any retaliatory acts may be subject to discipline, up to and including termination of employment.

Referrals of FWA to Government Agencies

CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies.

Certification

All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.

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9 Discrimination

CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.

- **No Discrimination:** Prohibited on the basis of race, gender, disability, etc..
- **Reassignment:** Must not be based on health status.

No Discrimination

CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above.

Reassignment

CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.

10 Participation Status

CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

- **Eligibility:** Must not be excluded from federal/state programs.
- **Screening:** Regular exclusion checks are conducted.
- **Disclosure:** Report any investigations or disciplinary actions.
- **Licensure:** Maintain valid credentials.

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Federal and State Health Care Program Participation Status

Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs.

CalOptima Health Screening

CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies.

Disclosure of Participation Status

Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program.

Delegated Third Party Administrator Review

CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them.

Licensure

CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.

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11 Government Inquiries / Legal Disputes

Employees and contractors shall notify CalOptima Health upon receipt of government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

- **Notification:** Inform Compliance immediately upon receiving inquiries.
- **No Destruction:** Do not alter or destroy documents.
- **Preservation:** Follow legal instructions for data retention.

Notification of Government Inquiry

Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health.

No Destruction of Documents

Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction.

Preservation of Documents Including Electronically Stored Information

Board members, employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

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Frequently Asked Questions

What constitutes an unfair competitive advantage for an employee's outside business activity?

An unfair competitive advantage occurs when an employee's outside employment, consulting, or business activity influences decisions made by CalOptima Health, thereby giving an unfair advantage to the employee's outside business.

Can CalOptima Health employees use privileged or official information for personal gain?

No, the use of privileged or official information for personal financial gain is prohibited. This applies to both current employees and those who have separated from employment. Privileged information includes, but is not limited to, personal health information (PHI), provider rates, personnel records, and proprietary information not available to the public.

Are employees allowed to use information obtained from CalOptima Health in their outside consulting work?

No, employees acting as independent consultants or as employees of another organization cannot use proprietary information, skills, or knowledge obtained from CalOptima Health, especially if it pertains to current, in-progress, or proposed projects that are not yet public.

Is outside employment or consulting activity allowed if it competes with CalOptima Health?

No, an employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs, or initiatives.

Can CalOptima Health employees handle issues for family or personal friends?

No, employees are prohibited from handling member or provider issues, applications, requests, or cases on behalf of CalOptima Health for their own family members or personal friends.

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What should an employee do if the employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member?

The employee must disclose this fact in writing to HR. For example, if CalOptima Health is considering contracting with a vendor for which your spouse is an employee, you must disclose this in writing to HR.

Are CalOptima Health employees allowed to perform a second job?

Employees are prohibited from performing a second job that creates a conflict of interest. They must report any non-CalOptima Health job positions that might create such a conflict and complete an Employee Report of Outside Interest and/or Other Employment form for HR approval.

What activities require prior written approval from the Chief Executive Officer or the Chair of the CalOptima Health Board of Directors?

The following activities require prior written approval:

- Performing work or rendering services for any contractor/vendor/provider or related association that does or seeks to do business with CalOptima Health.
- Performing work or holding a position with a job-related non-profit/charitable business or organization.
- Being a director, officer, or consultant of any contractor/vendor/provider or related association that does or seeks to do business with CalOptima Health.
- Allowing your name to be used in a manner that indicates a business connection with any contractor/vendor/provider or related association that does or seeks to do business with CalOptima Health.

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CalOptima Health

CalOptima Health, A Public Agency
505 City Parkway West, Orange, CA 92868
caloptima.org

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Orange County Health Authority
dba CalOptima Health

~~2026~~ 2027 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 202~~5~~6)

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I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies.

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CalOptima Health will submit its anti-fraud plan to the Department of Managed Health Care (DMHC). Any changes will be filed with DMHC pursuant to Health and Safety Code (HSC) § 1352. The submission will describe the manner in which the plan is complying with HSC § 1348(a), and the name and telephone number of the contact person to whom inquiries concerning the anti-fraud plan may be directed.

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IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

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Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;

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- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates, codes, names).

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- ► Photocopies of claim forms and bills, or handwritten claims and bills.
- ► Provider's last name is the same as the member/patient's last name.
- ► The insured's address is the same as the servicing provider.
- ► Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- ► Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- ► The allegation is logged into the case management system;
- ► The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- ► SIU develops an investigative plan;
- ► SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- ► Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- ► Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- ► SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- ► SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- ► Review of FDR enrollment applications, history, and ownership
- ► Review of member enrollment applications and other documents, as necessary;
- ► Review of applicable contracts and/or All Plan Letters (APLs);
- ► Discuss allegation and evidence collected with subject matter experts;
- ► All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- ► After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- ► The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods;
- ► If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- ► If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and

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Compliance Committee. If a CalOptima Health internal department or FDR has repeated disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, DMHC, Covered California, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS, Covered California, DMHC, and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare program.

For the purposes of reporting FWA to Covered California:

- CalOptima Health shall communicate within ten (10) days to Covered California any material concerns identified by CalOptima Health or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by State and Federal Regulators related to regulatory compliance that may impact performance under the contract with Covered California following CalOptima Health's knowledge of such occurrence; provided, however, such notification shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California members. All notifications shall be made according to the "Contract Reporting Requirements" table posted on CalOptima Health's extranet website provided by Covered California.
- If CalOptima Health receives any preliminary or final reports, findings, or orders related to material concerns identified by State and Federal Regulators that may impact performance under the contract with Covered California pursuant to Section 1.15 of the 6.5. Qualified Health Plans (QHP) contract, CalOptima Health shall provide Covered California with copies of them within 48 hours of receiving them from State and Federal Regulators.
- CalOptima Health shall provide Covered California with a description of its FWA detection and prevention programs and report total monies recovered by CalOptima Health in the most recent 12-month period for CalOptima Health's total book of business as well as, total monies recovered for Covered California business only. This description shall be updated during each year that the contract with Covered California is in effect and shall include an overview of fraud and abuse detection and prevention program activities conducted by CalOptima Health, Participating Providers, other Subcontractors and their authorized Agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.
- CalOptima Health maintains and enforces a written Code of Conduct publicly available on CalOptima Health's website.

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- CalOptima Health shall refer potential fraud activities identified through fraud detection and response measures to Covered California. CalOptima Health shall follow the established Carrier Referral Process posted on the Contractor's extranet website provided by Covered California.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- Schemes with large financial risk to CalOptima Health, or its members.

b. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, prepayment claim review, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. The SIU will track and trend the FWA allegation and investigation, including, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

CalOptima Health will not terminate Covered California member coverage for fraud without prior review and approval from Covered California.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

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VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance Training
- HH.2028: Code of Conduct
- HH.3012: Non-Retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

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Orange County Health Authority
dba CalOptima Health

2027 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 2026)

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Document maintained by: Fay Ho
CalOptima Health Director FWA

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a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

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Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;

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- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates, codes, names).

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- ► Photocopies of claim forms and bills, or handwritten claims and bills.
- ► Provider's last name is the same as the member/patient's last name.
- ► The insured's address is the same as the servicing provider.
- ► Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- ► Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- ► The allegation is logged into the case management system;
- ► The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- ► SIU develops an investigative plan;
- ► SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- ► Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- ► Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- ► SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- ► SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- ► Review of FDR enrollment applications, history, and ownership
- ► Review of member enrollment applications and other documents, as necessary;
- ► Review of applicable contracts and/or All Plan Letters (APLs);
- ► Discuss allegation and evidence collected with subject matter experts;
- ► All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- ► After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- ► The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods;
- ► If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- ► If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and

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Compliance Committee. If a CalOptima Health internal department or FDR has repeated disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, DMHC, Covered California, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS, Covered California, DMHC, and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare program.

For the purposes of reporting FWA to Covered California:

- CalOptima Health shall communicate within ten (10) days to Covered California any material concerns identified by CalOptima Health or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by State and Federal Regulators related to regulatory compliance that may impact performance under the contract with Covered California following CalOptima Health's knowledge of such occurrence; provided, however, such notification shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California members. All notifications shall be made according to the "Contract Reporting Requirements" table posted on CalOptima Health's extranet website provided by Covered California.
- If CalOptima Health receives any preliminary or final reports, findings, or orders related to material concerns identified by State and Federal Regulators that may impact performance under the contract with Covered California pursuant to Section 1.15 of the 6.5. Qualified Health Plans (QHP) contract, CalOptima Health shall provide Covered California with copies of them within 48 hours of receiving them from State and Federal Regulators.
- CalOptima Health shall provide Covered California with a description of its FWA detection and prevention programs and report total monies recovered by CalOptima Health in the most recent 12-month period for CalOptima Health's total book of business as well as, total monies recovered for Covered California business only. This description shall be updated during each year that the contract with Covered California is in effect and shall include an overview of fraud and abuse detection and prevention program activities conducted by CalOptima Health, Participating Providers, other Subcontractors and their authorized Agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.
- CalOptima Health maintains and enforces a written Code of Conduct publicly available on CalOptima Health's website.

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- CalOptima Health shall refer potential fraud activities identified through fraud detection and response measures to Covered California. CalOptima Health shall follow the established Carrier Referral Process posted on the Contractor's extranet website provided by Covered California.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;
- Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- Allegations involving known patterns of FWA;
- Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- Schemes with large financial risk to CalOptima Health, or its members.

b. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, prepayment claim review, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. The SIU will track and trend the FWA allegation and investigation, including, the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

CalOptima Health will not terminate Covered California member coverage for fraud without prior review and approval from Covered California.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

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VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance Training
- HH.2028: Code of Conduct
- HH.3012: Non-Retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

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~~2026~~ 2027 HIPAA Privacy and Security Program

Protection of Member Health Information

(Revised September 202~~5~~6)

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I. OBJECTIVES

This program description is a general introduction for all CalOptima Health employees to the privacy and security regulations dictated by the federal Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), other federal and California privacy laws, as well as CalOptima HIPAA security and privacy policies and procedures. This program description will be updated as needed and reviewed on an annual basis.

It is expected that all CalOptima Health employees understand that it is their legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all confidential information in accordance with these laws, policies, and procedures.

All employees are expected to access, use, and disclose confidential information only in the performance of their duties or when required or permitted by law. Additionally, all employees must disclose information only to persons who have the right to receive that information.

II. HIPAA PRIVACY AND CONFIDENTIALITY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which, in part, protects the privacy of individually identifiable member information, provides for the electronic and physical security of health and member medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers, health plans, their employees and other members of the covered entities' workforce. HIPAA privacy and security standards were updated in 2009 by the Health Information Technology for Economic and Clinical Health (HITECH) Act and in 2013 by the HIPAA Final Omnibus Rule.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule. The Privacy Rule sets the standards for how all protected health information (PHI) should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose information, what processes must be in place to control the access, use, and disclosure of information, and member rights.

The Security Rule defines the standards for covered entities' basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access to electronic information, and to protect it from accidental or intentional disclosure to unauthorized persons and from alteration, destruction, or loss. The standards include

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administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

III. DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

The HIPAA privacy regulations apply to "protected health information" (PHI). This term is used throughout this HIPAA Privacy and Security Program as well as in the policies and procedures.

Protected Health Information (PHI) has the meaning in 45 Code of Federal Regulations (CFR) § 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media (ePHI), or transmitted or maintained in any other form or medium. This information identifies the individual, or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or its Business Associate(s) and relates to:

1. The past, present, or future physical or mental health or condition of a member;
2. The provision of health care to a member; or
3. Past, present, or future payment for the provision of health care to a member.

PHI excludes:

1. Education records covered by the Family Educational Rights and Privacy Act;
2. Health records held by post-secondary educational institutions; and
3. Employment records held by a covered entity in its role as employer.

Electronic Protected Health Information (EPHI) is individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

What is not considered PHI?

Health information is not PHI if it is de-identified. De-identified information may be used without restriction and without member authorization. The de-identification standard provides a method for which health information can be designated as de-identified. This method requires the removal of all 18 identifying data elements listed in the regulations. To ensure that PHI is de-identified, two methods can be used to satisfy the Privacy Rule's de-identification standard as specific in 45 CFR §164.514(b)(1) Expert Determination, and 45 CFR §164.514(b)(2) Safe Harbor.

The identifiers of an individual or of relatives, employers, or household members of the individual, which must be removed, are:

1. Names;
2. Geographic subdivisions smaller than a State (addresses);

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3. Elements of dates (except year) for dates directly related to an individual (birthdates);
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical records numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate or license numbers;
12. Vehicle identifiers and serial numbers (license plate numbers);
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers (finger, eye, and voice prints);
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted by paragraph c of 45 CFR §164.514(b)(2).

What member information must we protect?

We must protect all PHI including, but not limited to medical/clinical records, prescriptions, billing records, claim data, referral authorizations, member notifications such as explanation of benefits and other member materials including marketing materials that contain PHI.

We have implemented controls, as well as policies and procedures, for protecting member information pertaining to race, ethnicity, language, gender identity[1], and sexual orientation[2].

Offshore Subcontracting

We require appropriate oversight of offshore subcontractors that access, use, store, process, or transmit PHI, Personally Identifiable Information (PII), or other confidential information. Offshore arrangements must be disclosed, reviewed, and approved before access is permitted. Also, offshore arrangements must meet applicable privacy, security, contractual, CMS, DHCS, and other regulatory requirements.

We require applicable vendors, business associates, delegated entities, and subcontractors to disclose offshore activities and complete the required offshore attestation. Appropriate

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[1] **Gender identity** is defined as an individual's innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual's gender identity may be the same or different from the sex assigned at birth.
[2] **Sexual orientation**, which is separate from gender identity, is defined as an inherent or immutable and enduring emotional, romantic or sexual attraction or nonattraction to individuals of the same and/or other genders.

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safeguards, monitoring, and corrective actions must be maintained to protect our members' information.

IV. THE PRIVACY RULE AND THE SECURITY RULE

Purpose of Privacy Rule

The purpose of the Privacy Rule is to protect and enhance the rights of members by providing them access to their health information and controlling the inappropriate use of that information.

Highlights of Privacy Rule

The Privacy Rule requires that access to PHI, including ePHI, by CalOptima Health employees is based on the general principles of "need to know" and "minimum necessary," wherein access is limited only to the member information needed to perform a job function.

The Privacy Rule also affords certain rights to members, such as the right to request copies of their health records in paper or electronic format, or to request an amendment of information in their records.

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy. These penalties range from $141 per violation to $2,134,831 per violation (with an annual penalty limit of $2,134,831), in addition to costs and attorneys' fees and costs, depending on the type of violation. In addition to civil monetary penalties, other consequences may include civil lawsuits, misdemeanor and felony charges, the reporting of individual violators to licensing boards for violations, and imprisonment.

Purpose of Security Rule

The Security Rule encompasses physical, administrative, and technical security, including computer systems and transmissions of ePHI. The rule's purpose is to:

- Ensure the confidentiality, integrity, and availability of all ePHI that is created, received, maintained, or transmitted by the covered entity.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI.
- Protect against unauthorized uses or disclosures of ePHI.
- Ensure compliance of the covered entity's workforce.

Definition of Security

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"**Security**" is defined as having controls, countermeasures, and procedures in place to ensure the appropriate protection of information assets, and to control access to valued resources. The purpose of security is to minimize the vulnerability of assets and resources.

Requirements and Responsibility for Security

CalOptima Health's Information Cybersecurity Department is responsible for maintaining, monitoring, storing and securing transmission of ePHI data along with oversight of all policies and procedures regarding the security of CalOptima Health information assets.

CalOptima Health employees are responsible for protecting all of CalOptima Health's electronic information resources under their control by employing appropriate and applicable security controls.

Protection of CalOptima Health electronic information resources encompasses:

- Safeguarding ePHI from accidental or intentional disclosure to unauthorized persons.
- Safeguarding ePHI from accidental or intentional alteration, destruction, or loss.
- Safeguarding systems from viruses and malware.
- Taking precautions that will minimize the potential for theft, destruction, or any type of loss.
- Protecting workstations and mobile devices from unauthorized access and theft (e.g., via encryption, password authenticated access and physical lockdown) to ensure that ePHI is accessed, used, and/or disclosed only by authorized persons.
- Protecting other electronic assets and storage media (e.g., USB thumb drives, external hard drives, CD-ROM/DVD disks, floppy disks, magnetic tapes, videotapes, SD memory cards, etc.) from unauthorized access and theft, to ensure that ePHI contained within is accessed, used, and/or disclosed only by authorized persons.

V. WRITTEN POLICIES AND PROCEDURES FOR HIPAA PRIVACY PROGRAM

CalOptima Health's policies and procedures for the HIPAA Privacy and Security Program are located on CalOptima Health's intranet, InfoNet, which is accessible to all employees. Policies and procedures are available to CalOptima providers and health networks on CalOptima Health's website.

CalOptima Health maintains the written policies and procedures and other records related to implementation for ten years from the date created or the date last in effect, whichever is later.

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VI. PRIVACY OFFICER, CHIEF INFORMATION SECURITY OFFICER AND COMPLIANCE COMMITTEE

The Privacy Officer and Chief Information Security Officer (CISO) shall work with the Compliance Committee to assist in the implementation of the HIPAA Privacy and Security Program. The Compliance Committee is chaired by the Chief Compliance Officer (CCO), and the members of the Compliance Committee are comprised of key stake holders in the HIPAA Privacy and Security Program, including the Privacy Officer, the CISO, Legal Counsel, Chief Executive Officer (CEO), and Chief Operations Officer (COO). This Committee is responsible for overseeing the following activities:

- Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy policies and procedures as part of daily operations;
- Determining the appropriate strategy/approach to promote compliance with the Privacy Program and Security Program and detection of any potential violations, such as through hotlines and other reporting mechanisms;
- Developing a system to solicit, evaluate and respond to referrals for privacy investigations, security incidents and breaches;
- Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;
- Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, security incident reports, referrals for privacy investigations, etc.;
- Analyzing and data collecting of business processes, systems and relationships to understand the cause of a reportable security incident/HIPAA breach;
- Developing policies to better prevent or address reportable security incidents/HIPAA breaches; and
- Developing resolutions which stem from reportable security incidents/HIPAA breaches.

When a potential problem is identified, the Privacy Officer and the CISO may convene a designated group of individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

VII. GENERAL PROVISIONS ON SAFEGUARDS AND MITIGATION PROCEDURES

Security Safeguards

CalOptima Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in all forms including electronic

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and hard copy. CalOptima Health employees are trained and educated on the HIPAA Security regulations to ensure that reasonable measures are taken to safeguard PHI from any use or disclosure that would violate the HIPAA regulations or CalOptima's privacy policies. CalOptima Health employees have limited access to PHI through job-based access and password protection. CalOptima Health also has security tools in place to protect information from those who do not need to access PHI to perform their job functions. CalOptima Health's established physical safeguards include electronic building access, restricted area access, limited access to mailroom processing, clean desk policy and controlled system access to PHI for employees and contracted personnel to perform their job function.

CalOptima Health has processes to limit employee access to member PHI based on the employee's role and job description. Employees have an obligation to limit the use of PHI to the minimum necessary for their business purposes. CalOptima Health prohibits the use of employee-owned equipment within CalOptima Health's network and employees may not transfer PHI to any portable devices for storage or otherwise without the express permission of CalOptima Health's ITS Department, which if granted, will be processed in accordance with ITS policies and procedures. CalOptima Health data including member PHI may only be used in connection with business purposes.

E-mail Safeguards

E-mail communications between CalOptima Health and an external entity via the internet shall not contain member identifiable PHI unless the e-mail has been encrypted to safeguard the contents from being read by anyone other than the intended receiver. E-mail that is sent within CalOptima Health may contain member identifiable PHI but must be limited to the minimum necessary data required to complete the message.

Mass Disclosure Safeguards

Any large mailings that include PHI must be carefully reviewed to ensure that PHI is not inadvertently revealed to an unintended recipient. For example, this might include targeted mailings to members with specific health conditions or disease states (e.g., mailings to members with HIV). Electronic and non-electronic data must be appropriately safeguarded to ensure that PHI is protected, pursuant to CalOptima Health policies and procedures.

VIII. EDUCATION AND TRAINING PROGRAMS

CalOptima Health conducts regular training sessions on the HIPAA regulations, the CalOptima Health Privacy Program, the CalOptima Health ITS Cybersecurity awareness program, and the policies and procedures. All new employees are provided with training within a reasonable period at the New Employee Orientation. All CalOptima Health employees are also required to complete an annual mandatory online Compliance training, which includes a module on HIPAA privacy and security compliance. CalOptima Health

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shall maintain an annual log of training completion dates and assessment scores for all employees. Focused training will be provided as needed. Failure to complete the mandatory training within the specified timeframe may lead to disciplinary action up to and including termination of the employee.

CalOptima Health will periodically update the policies and procedures to reflect changes in operations or changes to applicable statutes and regulations. CalOptima Health will distribute the updates to affected employees and will provide additional training as necessary to ensure that employees and/or contracted personnel understand the revised policies and procedures.

IX. EFFECTIVE LINES OF COMMUNICATION

Member Complaint Procedure

CalOptima Health has procedures in place for handling complaints from its members regarding implementation of and compliance with the HIPAA privacy regulations as well as State and Federal privacy laws. CalOptima Health's Notice of Privacy Practices directs members with complaints to contact CalOptima Health, the DHCS Privacy Officer, the Secretary of the Health and Human Services or the Office for Civil Rights. Upon receipt of a complaint, the Customer Service Department will provide a copy of each complaint to CalOptima Health's Privacy Officer and forward the complaint to the Grievance and Appeals Resolution Services Department (GARS). GARS will follow the same procedure as when handling other complaints submitted by CalOptima Health members. All responses and other documentation relating to a privacy complaint are maintained in the member's file and by the Privacy Officer for ten years from the date of the last communication on the complaint.

Access to Privacy Officer

The Privacy Officer maintains an open door policy for all employees and accepts e-mails, telephone messages or written memoranda regarding any privacy matter. Any individual who has a question or wants to report a potential privacy incident may bring such issues directly to the Privacy Officer, CCO, or CISO. Reports of potential privacy incidents may be made on an anonymous or identifiable basis directly to the Privacy Officer or through the Compliance Hotline at 1-855-507-1805.

Responsibility to Report

CalOptima Health is committed to compliance with the HIPAA and state privacy laws and to correcting violations wherever they may occur in the organization. Every employee is responsible for reporting any activity they suspect violates applicable privacy and security laws, rules, regulations or the HIPAA Privacy and Security Program. CalOptima Health must notify the Department of Health Care Services (DHCS) of any suspected or actual

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security incident and breaches of unsecure (unencrypted) protected information or other unauthorized use or disclosure of our members' PHI and provide a written report of the investigation. On an as needed basis, CalOptima Health shall notify the Centers for Medicare & Medicaid Services (CMS), and/or the Department of Health and Human Services, Office of Civil Rights (OCR), and/or the California Attorney General of actual privacy and security breaches. The Office of Compliance will maintain documentation of incidents, including the nature of any investigation, mitigation and corrective action. In addition, employees and members have the right to report violations to the California DHCS Privacy Officer or the Secretary of the Department of Health and Human Services (DHHS). Contact information is below:

Department of Health Care Services
Attention: Office of HIPAA Compliance
P.O. Box 997413, MS 4721
Sacramento, CA 95899-7413
Phone: (916) 552-9444
Fax: (916) 440-7680
Email: hipaateam@dhcs.ca.gov

OR

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

In addition, employees who have observed a security incident or HIPAA breach (e.g., unsecured transmission of PHI, etc.) may contact the Compliance Hotline anonymously at: 1-855-507-1805, CalOptima Health's Privacy Officer at Privacy@caloptima.org, or CISO.

Confidentiality and No Retaliation

CalOptima Health will not threaten, intimidate, discriminate, or take other retaliatory action against any individual for filing HIPAA complaints, assisting in HIPAA investigations or compliance reviews, or raising concerns with any act or practice that they suspect is in violation of HIPAA and/or state privacy laws when the individual has a good faith belief that the act may be unlawful.

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X. ENFORCING STANDARDS THROUGH DISCIPLINARY GUIDELINES

All violators of the HIPAA Privacy and Security Program or of the policies and procedures will be subject to disciplinary action. The precise discipline will depend on the nature and severity of the violation.

Disciplinary Guidelines

Any employee who fails to comply with CalOptima Health's HIPAA Privacy and Security Program or its policies and procedures is subject to focused and/or additional training or discipline. In coordination with CalOptima Health Policy GA.8022: Performance and Behavior Standards, such discipline may include: 1) a verbal warning; 2) written warning; 3) suspension; or 4) termination. The type of discipline rendered will depend on the degree of wrongdoing, whether there have been past violations and the individual's cooperation in promptly reporting the incident to the appropriate manager or to the Privacy Officer. Intentional or reckless non-compliance will not be tolerated and will subject the employee to discipline up to and including termination of employment.

CalOptima Health's Office of Compliance may require that an internal department or FDR develop a Corrective Action Plan based on the identified area(s) of non-compliance identified from the HIPAA and/or state privacy laws violation.

Consistent Enforcement of Policies

The range of disciplinary standards for improper conduct will be consistently applied and enforced. All personnel will be treated equally, and disciplinary action will be taken on a fair and equitable basis. CalOptima Health management must comply with and take action to ensure that their direct reports comply with the applicable policies and procedures.

Education on Disciplinary Guidelines

In the training sessions, all employees will be advised of the policy regarding disciplinary actions for non-compliance.

XI. RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION PLANS

Investigation and Corrective Action

If there is a report of non-compliance, or if the Privacy Officer, CISO, a member of the Compliance Committee, or a manager discovers credible evidence of a violation, an investigation will immediately ensue. When CalOptima Health substantiates a reported violation, it is the policy to institute corrective action.

Initiating Systemic Changes to Correct Problems

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After a problem has been identified and corrected, the Privacy Officer, CISO, and the Compliance Committee will review the circumstances to determine: 1) whether similar problems have been uncovered elsewhere, and 2) whether modifications of the privacy policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy Officer and CISO will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

Mitigation

If a suspected or actual use or disclosure occurs by CalOptima Health or a business associate that violates the HIPAA regulations and/or state privacy laws, CalOptima Health will take prompt corrective action to mitigate any damaging effects that the potential disclosure could have on the affected members as well as cure any system deficiencies to prevent future unauthorized uses or disclosures. CalOptima Health employees and FDRs are required to report any suspected or actual violation that they observe or learn about to his/her supervisor, or the Privacy Officer, CCO, or CISO immediately so that action to mitigate the damage can commence promptly.

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CalOptima Health

2027 HIPAA Privacy and Security Program

Protection of Member Health Information

(Revised September 2026)

For 20261105 BOD Review Only

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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I. OBJECTIVES

This program description is a general introduction for all CalOptima Health employees to the privacy and security regulations dictated by the federal Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), other federal and California privacy laws, as well as CalOptima HIPAA security and privacy policies and procedures. This program description will be updated as needed and reviewed on an annual basis.

It is expected that all CalOptima Health employees understand that it is their legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all confidential information in accordance with these laws, policies, and procedures.

All employees are expected to access, use, and disclose confidential information only in the performance of their duties or when required or permitted by law. Additionally, all employees must disclose information only to persons who have the right to receive that information.

II. HIPAA PRIVACY AND CONFIDENTIALITY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which, in part, protects the privacy of individually identifiable member information, provides for the electronic and physical security of health and member medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers, health plans, their employees and other members of the covered entities' workforce. HIPAA privacy and security standards were updated in 2009 by the Health Information Technology for Economic and Clinical Health (HITECH) Act and in 2013 by the HIPAA Final Omnibus Rule.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule. The Privacy Rule sets the standards for how all protected health information (PHI) should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose information, what processes must be in place to control the access, use, and disclosure of information, and member rights.

The Security Rule defines the standards for covered entities' basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access to electronic information, and to protect it from accidental or intentional disclosure to unauthorized persons and from alteration, destruction, or loss. The standards include

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administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

III. DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

The HIPAA privacy regulations apply to "protected health information" (PHI). This term is used throughout this HIPAA Privacy and Security Program as well as in the policies and procedures.

Protected Health Information (PHI) has the meaning in 45 Code of Federal Regulations (CFR) § 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media (ePHI), or transmitted or maintained in any other form or medium. This information identifies the individual, or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or its Business Associate(s) and relates to:

1. The past, present, or future physical or mental health or condition of a member;
2. The provision of health care to a member; or
3. Past, present, or future payment for the provision of health care to a member.

PHI excludes:

1. Education records covered by the Family Educational Rights and Privacy Act;
2. Health records held by post-secondary educational institutions; and
3. Employment records held by a covered entity in its role as employer.

Electronic Protected Health Information (EPHI) is individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

What is not considered PHI?

Health information is not PHI if it is de-identified. De-identified information may be used without restriction and without member authorization. The de-identification standard provides a method for which health information can be designated as de-identified. This method requires the removal of all 18 identifying data elements listed in the regulations. To ensure that PHI is de-identified, two methods can be used to satisfy the Privacy Rule's de-identification standard as specific in 45 CFR §164.514(b)(1) Expert Determination, and 45 CFR §164.514(b)(2) Safe Harbor.

The identifiers of an individual or of relatives, employers, or household members of the individual, which must be removed, are:

1. Names;
2. Geographic subdivisions smaller than a State (addresses);

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3. Elements of dates (except year) for dates directly related to an individual (birthdates);
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical records numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate or license numbers;
12. Vehicle identifiers and serial numbers (license plate numbers);
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers (finger, eye, and voice prints);
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted by paragraph c of 45 CFR §164.514(b)(2).

What member information must we protect?

We must protect all PHI including, but not limited to medical/clinical records, prescriptions, billing records, claim data, referral authorizations, member notifications such as explanation of benefits and other member materials including marketing materials that contain PHI.

We have implemented controls, as well as policies and procedures, for protecting member information pertaining to race, ethnicity, language, gender identity[1], and sexual orientation[2].

Offshore Subcontracting

We require appropriate oversight of offshore subcontractors that access, use, store, process, or transmit PHI, Personally Identifiable Information (PII), or other confidential information. Offshore arrangements must be disclosed, reviewed, and approved before access is permitted. Also, offshore arrangements must meet applicable privacy, security, contractual, CMS, DHCS, and other regulatory requirements.

We require applicable vendors, business associates, delegated entities, and subcontractors to disclose offshore activities and complete the required offshore attestation. Appropriate

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[1] **Gender identity** is defined as an individual's innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual's gender identity may be the same or different from the sex assigned at birth.
[2] **Sexual orientation**, which is separate from gender identity, is defined as an inherent or immutable and enduring emotional, romantic or sexual attraction or nonattraction to individuals of the same and/or other genders.

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safeguards, monitoring, and corrective actions must be maintained to protect our members' information.

IV. THE PRIVACY RULE AND THE SECURITY RULE

Purpose of Privacy Rule

The purpose of the Privacy Rule is to protect and enhance the rights of members by providing them access to their health information and controlling the inappropriate use of that information.

Highlights of Privacy Rule

The Privacy Rule requires that access to PHI, including ePHI, by CalOptima Health employees is based on the general principles of "need to know" and "minimum necessary," wherein access is limited only to the member information needed to perform a job function.

The Privacy Rule also affords certain rights to members, such as the right to request copies of their health records in paper or electronic format, or to request an amendment of information in their records.

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy. These penalties range from $141 per violation to $2,134,831 per violation (with an annual penalty limit of $2,134,831), in addition to costs and attorneys' fees and costs, depending on the type of violation. In addition to civil monetary penalties, other consequences may include civil lawsuits, misdemeanor and felony charges, the reporting of individual violators to licensing boards for violations, and imprisonment.

Purpose of Security Rule

The Security Rule encompasses physical, administrative, and technical security, including computer systems and transmissions of ePHI. The rule's purpose is to:

- Ensure the confidentiality, integrity, and availability of all ePHI that is created, received, maintained, or transmitted by the covered entity.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI.
- Protect against unauthorized uses or disclosures of ePHI.
- Ensure compliance of the covered entity's workforce.

Definition of Security

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"**Security**" is defined as having controls, countermeasures, and procedures in place to ensure the appropriate protection of information assets, and to control access to valued resources. The purpose of security is to minimize the vulnerability of assets and resources.

Requirements and Responsibility for Security

CalOptima Health's Information Cybersecurity Department is responsible for maintaining, monitoring, storing and securing transmission of ePHI data along with oversight of all policies and procedures regarding the security of CalOptima Health information assets.

CalOptima Health employees are responsible for protecting all of CalOptima Health's electronic information resources under their control by employing appropriate and applicable security controls.

Protection of CalOptima Health electronic information resources encompasses:

- Safeguarding ePHI from accidental or intentional disclosure to unauthorized persons.
- Safeguarding ePHI from accidental or intentional alteration, destruction, or loss.
- Safeguarding systems from viruses and malware.
- Taking precautions that will minimize the potential for theft, destruction, or any type of loss.
- Protecting workstations and mobile devices from unauthorized access and theft (e.g., via encryption, password authenticated access and physical lockdown) to ensure that ePHI is accessed, used, and/or disclosed only by authorized persons.
- Protecting other electronic assets and storage media (e.g., USB thumb drives, external hard drives, CD-ROM/DVD disks, floppy disks, magnetic tapes, videotapes, SD memory cards, etc.) from unauthorized access and theft, to ensure that ePHI contained within is accessed, used, and/or disclosed only by authorized persons.

V. WRITTEN POLICIES AND PROCEDURES FOR HIPAA PRIVACY PROGRAM

CalOptima Health's policies and procedures for the HIPAA Privacy and Security Program are located on CalOptima Health's intranet, InfoNet, which is accessible to all employees. Policies and procedures are available to CalOptima providers and health networks on CalOptima Health's website.

CalOptima Health maintains the written policies and procedures and other records related to implementation for ten years from the date created or the date last in effect, whichever is later.

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VI. PRIVACY OFFICER, CHIEF INFORMATION SECURITY OFFICER AND COMPLIANCE COMMITTEE

The Privacy Officer and Chief Information Security Officer (CISO) shall work with the Compliance Committee to assist in the implementation of the HIPAA Privacy and Security Program. The Compliance Committee is chaired by the Chief Compliance Officer (CCO), and the members of the Compliance Committee are comprised of key stake holders in the HIPAA Privacy and Security Program, including the Privacy Officer, the CISO, Legal Counsel, Chief Executive Officer (CEO), and Chief Operations Officer (COO). This Committee is responsible for overseeing the following activities:

- Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy policies and procedures as part of daily operations;
- Determining the appropriate strategy/approach to promote compliance with the Privacy Program and Security Program and detection of any potential violations, such as through hotlines and other reporting mechanisms;
- Developing a system to solicit, evaluate and respond to referrals for privacy investigations, security incidents and breaches;
- Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;
- Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, security incident reports, referrals for privacy investigations, etc.;
- Analyzing and data collecting of business processes, systems and relationships to understand the cause of a reportable security incident/HIPAA breach;
- Developing policies to better prevent or address reportable security incidents/HIPAA breaches; and
- Developing resolutions which stem from reportable security incidents/HIPAA breaches.

When a potential problem is identified, the Privacy Officer and the CISO may convene a designated group of individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

VII. GENERAL PROVISIONS ON SAFEGUARDS AND MITIGATION PROCEDURES

Security Safeguards

CalOptima Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in all forms including electronic

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and hard copy. CalOptima Health employees are trained and educated on the HIPAA Security regulations to ensure that reasonable measures are taken to safeguard PHI from any use or disclosure that would violate the HIPAA regulations or CalOptima's privacy policies. CalOptima Health employees have limited access to PHI through job-based access and password protection. CalOptima Health also has security tools in place to protect information from those who do not need to access PHI to perform their job functions. CalOptima Health's established physical safeguards include electronic building access, restricted area access, limited access to mailroom processing, clean desk policy and controlled system access to PHI for employees and contracted personnel to perform their job function.

CalOptima Health has processes to limit employee access to member PHI based on the employee's role and job description. Employees have an obligation to limit the use of PHI to the minimum necessary for their business purposes. CalOptima Health prohibits the use of employee-owned equipment within CalOptima Health's network and employees may not transfer PHI to any portable devices for storage or otherwise without the express permission of CalOptima Health's ITS Department, which if granted, will be processed in accordance with ITS policies and procedures. CalOptima Health data including member PHI may only be used in connection with business purposes.

E-mail Safeguards

E-mail communications between CalOptima Health and an external entity via the internet shall not contain member identifiable PHI unless the e-mail has been encrypted to safeguard the contents from being read by anyone other than the intended receiver. E-mail that is sent within CalOptima Health may contain member identifiable PHI but must be limited to the minimum necessary data required to complete the message.

Mass Disclosure Safeguards

Any large mailings that include PHI must be carefully reviewed to ensure that PHI is not inadvertently revealed to an unintended recipient. For example, this might include targeted mailings to members with specific health conditions or disease states (e.g., mailings to members with HIV). Electronic and non-electronic data must be appropriately safeguarded to ensure that PHI is protected, pursuant to CalOptima Health policies and procedures.

VIII. EDUCATION AND TRAINING PROGRAMS

CalOptima Health conducts regular training sessions on the HIPAA regulations, the CalOptima Health Privacy Program, the CalOptima Health ITS Cybersecurity awareness program, and the policies and procedures. All new employees are provided with training within a reasonable period at the New Employee Orientation. All CalOptima Health employees are also required to complete an annual mandatory online Compliance training, which includes a module on HIPAA privacy and security compliance. CalOptima Health

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shall maintain an annual log of training completion dates and assessment scores for all employees. Focused training will be provided as needed. Failure to complete the mandatory training within the specified timeframe may lead to disciplinary action up to and including termination of the employee.

CalOptima Health will periodically update the policies and procedures to reflect changes in operations or changes to applicable statutes and regulations. CalOptima Health will distribute the updates to affected employees and will provide additional training as necessary to ensure that employees and/or contracted personnel understand the revised policies and procedures.

IX. EFFECTIVE LINES OF COMMUNICATION

Member Complaint Procedure

CalOptima Health has procedures in place for handling complaints from its members regarding implementation of and compliance with the HIPAA privacy regulations as well as State and Federal privacy laws. CalOptima Health's Notice of Privacy Practices directs members with complaints to contact CalOptima Health, the DHCS Privacy Officer, the Secretary of the Health and Human Services or the Office for Civil Rights. Upon receipt of a complaint, the Customer Service Department will provide a copy of each complaint to CalOptima Health's Privacy Officer and forward the complaint to the Grievance and Appeals Resolution Services Department (GARS). GARS will follow the same procedure as when handling other complaints submitted by CalOptima Health members. All responses and other documentation relating to a privacy complaint are maintained in the member's file and by the Privacy Officer for ten years from the date of the last communication on the complaint.

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security incident and breaches of unsecure (unencrypted) protected information or other unauthorized use or disclosure of our members' PHI and provide a written report of the investigation. On an as needed basis, CalOptima Health shall notify the Centers for Medicare & Medicaid Services (CMS), and/or the Department of Health and Human Services, Office of Civil Rights (OCR), and/or the California Attorney General of actual privacy and security breaches. The Office of Compliance will maintain documentation of incidents, including the nature of any investigation, mitigation and corrective action. In addition, employees and members have the right to report violations to the California DHCS Privacy Officer or the Secretary of the Department of Health and Human Services (DHHS). Contact information is below:

Department of Health Care Services
Attention: Office of HIPAA Compliance
P.O. Box 997413, MS 4721
Sacramento, CA 95899-7413
Phone: (916) 552-9444
Fax: (916) 440-7680
Email: hipaateam@dhcs.ca.gov

OR

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (800) 368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697
Email: ocrmail@hhs.gov

In addition, employees who have observed a security incident or HIPAA breach (e.g., unsecured transmission of PHI, etc.) may contact the Compliance Hotline anonymously at: 1-855-507-1805, CalOptima Health's Privacy Officer at Privacy@caloptima.org, or CISO.

Confidentiality and No Retaliation

CalOptima Health will not threaten, intimidate, discriminate, or take other retaliatory action against any individual for filing HIPAA complaints, assisting in HIPAA investigations or compliance reviews, or raising concerns with any act or practice that they suspect is in violation of HIPAA and/or state privacy laws when the individual has a good faith belief that the act may be unlawful.

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Disciplinary Guidelines

Any employee who fails to comply with CalOptima Health's HIPAA Privacy and Security Program or its policies and procedures is subject to focused and/or additional training or discipline. In coordination with CalOptima Health Policy GA.8022: Performance and Behavior Standards, such discipline may include: 1) a verbal warning; 2) written warning; 3) suspension; or 4) termination. The type of discipline rendered will depend on the degree of wrongdoing, whether there have been past violations and the individual's cooperation in promptly reporting the incident to the appropriate manager or to the Privacy Officer. Intentional or reckless non-compliance will not be tolerated and will subject the employee to discipline up to and including termination of employment.

CalOptima Health's Office of Compliance may require that an internal department or FDR develop a Corrective Action Plan based on the identified area(s) of non-compliance identified from the HIPAA and/or state privacy laws violation.

Consistent Enforcement of Policies

The range of disciplinary standards for improper conduct will be consistently applied and enforced. All personnel will be treated equally, and disciplinary action will be taken on a fair and equitable basis. CalOptima Health management must comply with and take action to ensure that their direct reports comply with the applicable policies and procedures.

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In the training sessions, all employees will be advised of the policy regarding disciplinary actions for non-compliance.

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If there is a report of non-compliance, or if the Privacy Officer, CISO, a member of the Compliance Committee, or a manager discovers credible evidence of a violation, an investigation will immediately ensue. When CalOptima Health substantiates a reported violation, it is the policy to institute corrective action.

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After a problem has been identified and corrected, the Privacy Officer, CISO, and the Compliance Committee will review the circumstances to determine: 1) whether similar problems have been uncovered elsewhere, and 2) whether modifications of the privacy policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy Officer and CISO will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

Mitigation

If a suspected or actual use or disclosure occurs by CalOptima Health or a business associate that violates the HIPAA regulations and/or state privacy laws, CalOptima Health will take prompt corrective action to mitigate any damaging effects that the potential disclosure could have on the affected members as well as cure any system deficiencies to prevent future unauthorized uses or disclosures. CalOptima Health employees and FDRs are required to report any suspected or actual violation that they observe or learn about to his/her supervisor, or the Privacy Officer, CCO, or CISO immediately so that action to mitigate the damage can commence promptly.

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Attachment 6: Summary of Proposed Actions for Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

POLICY & DEPARTMENT	REVISION, PROGRAM & CONTACTS	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS] E – ANNUAL REVIEW [NO EDITS]
HH.3001: Member Access to Designated Record Set *Privacy*	**B – REVISED:** This policy was updated to clarify applicable regulatory standards, enhance the security and protection of electronic health information and patient access application programming interfaces (APIs), and permit members to authorize any compliant third-party application to access information via the patient access API. References and glossary terms were also updated to align with current and contractual regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE	
HH.3014: Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII) *Privacy*	**B – REVISED:** This policy's language was updated to ensure the protection of PHI and personally identifiable information (PII) when sending emails both internally and externally. **Program(s):** Covered California; Medi-Cal; OneCare; PACE	
HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information *Privacy*	**B – REVISED:** This policy was updated to add provisions for members to designate an authorized representative for appeals and grievances and clarify CalOptima Health's requirements for obtaining member authorization when a member designates an individual or agency rather than a personal representative for the appeals and grievance process. References and glossary terms were also updated to align with current and contractual regulatory guidelines. **Program(s):** Covered California; Medi-Cal; OneCare; PACE	

POLICY & DEPARTMENT	REVISION, PROGRAM & CONTACTS	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS] E – ANNUAL REVIEW [NO EDITS]
HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII *Privacy*	**B – REVISED:** This policy was updated to include Privacy Officer requirements for assessing security incidents, breaches, or unauthorized disclosures of PHI/PII to determine whether they meet National Committee for Quality Assurance (NCQA) Reportable Event criteria and move Attachments A, B, and C to the references section. References and glossary terms were also updated to align with current and contractual regulatory guidelines. **Program(s):** Covered California; Medi-Cal; OneCare; PACE	
HH.3023: Information Sharing *Privacy*	**B – REVISED:** This policy was updated to establish directives for interoperability standards and governance regarding the collection, use, disclosure, and electronic access of PHI, PII, and United States Dore Data for Interoperability (USCDI). References and glossary terms were also updated to align with current and contractual regulatory guidelines. **Program(s):** Covered California; Medi-Cal; OneCare; PACE	
HH.4003: Annual Risk Assessment (Internal) *Internal Audit*	**B – REVISED:** This policy was revised to expand risk assessment considerations, clarify the lookback period, add directives for developing a risk taxonomy based on aggregate risk scores, and update language to clarify current processes. **Program(s):** Administrative	
HH.4004: Grant Audits/Reviews *Internal Audit*	**B – REVISED:** This policy was revised to clarify target timeframes for completing grant audit and review fieldwork, add provisions requiring expenditures and subcontracting to be authorized and aligned with grant purposes, and update language to clarify current processes. References and glossary terms were also updated to align with CalOptima Health policy(s) and current and contractual regulatory guidelines. **Program(s):** Administrative	

Policy:	HH.3001
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) ~~for a Member,~~ maintained by CalOptima Health and establishes the ~~conditions~~requirements under which ~~the~~a Member~~,~~ or ~~their~~ Personal Representative~~,~~ may ~~access,~~ inspect, ~~or~~ obtain ~~a copy of their~~, or electronically access PHI maintained in the DRS ~~or~~, including through ~~a Patient Access~~standards-based Application Programming ~~Interface (API).~~Interfaces (APIs), in accordance with the HIPAA Privacy Rule (45 CFR §164.524), 42 CFR §431.60, the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F), the Office of the National Coordinator for Health Information Technology (ONC) Cures Act Final Rule (45 CFR Part 171), and the Department of Health Care Services (DHCS) All Plan Letter (APL) 26-008: Interoperability Final Rules, Including Prior Authorization Requirements.

II. POLICY

A. Except as otherwise provided in Section III.A.~~9~~11. of this Policy, Members shall have the right of access to inspect and obtain a copy of their PHI in the DRS for as long as CalOptima Health maintains the PHI in the DRS.

B. CalOptima Health shall provide a Member with access to their PHI in the format requested by the Member, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima Health and the Member.

C. CalOptima Health shall grant a Member's Personal Representative access to a Member's PHI, in accordance with CalOptima Health Policies HH.3009: Access by Member's Personal Representative and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

D. CalOptima Health shall implement, maintain, monitor, and secure standards-based APIs that allow Members and their Personal Representatives to electronically access health information required under federal interoperability regulations using Third-Party Applications selected by the Member. CalOptima Health shall implement and maintain a secure, standards-based Patient Access API that shall connect to provider electronic health records and practice management systems, in accordance with requirements specified at 42 CFR section 431.60~~.~~, including claims data, encounter data, clinical data maintained by CalOptima Health, prior authorization information, covered outpatient drugs and

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other information required by CMS or DHCS. Electronic access through the Patient Access API shall be available independent of the HIPAA right-of-access process and shall not require submission of a written HIPAA access request.

1. CalOptima Health shall permit third-party applications, such as an API, to retrieve data specified in the Patient Access Rule, through the use of common technologies and without special effort from the Member, with the approval and the direction of a Member or Member's Personal Representative.

2. Technical safeguards, data protection controls, system testing, monitoring, and regulatory compliance requirements applicable to the Patient Access API are governed by CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls, and related Information Technology and Information Security policies.

E. CalOptima Health shall not engage in practices likely to interfere with, prevent, materially discourage, or delay lawful access, exchange, or use of electronic health information except as expressly permitted under federal regulations governing information blocking.

~~D.~~F. Any person with knowledge of a violation, or potential violation, of this Policy shall report such information to the Privacy Officer directly, or through the CalOptima Health Compliance and Ethics Hotline at 1-855-507-1805 or email: privacy@caloptimahealth.org.

G. Members may authorize any compliant third-party application to retrieve information through the Patient Access API. Prior to disclosure, CalOptima Health shall provide the Member with educational information explaining that once information is disclosed to a Third-Party Application that is not a HIPAA Covered Entity or Business Associate, HIPAA protections may no longer apply.

H. CalOptima Health shall maintain administrative, technical, and physical safeguards protecting Patient Access APIs including:

1. OAuth 2.0;

2. SMART on FHIR;

3. TLS encryption;

4. Audit logging;

5. Continuous monitoring;

6. Vulnerability management;

7. Token expiration;

8. Identity verification; and

9. Incident response procedures.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of DRS:

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1. A Member shall submit a written request for access to inspect or obtain a copy of their PHI in the DRS by submitting the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D) to the Office of Compliance. A Member's Personal Representative may request access to the Member's PHI in accordance with the requirements set forth in CalOptima Health Policy HH.3009: Access by Member's Personal Representative. This requirement does not apply to electronic access obtained through standards-based Patient Access APIs.

    a. Member or their Personal Representative has the right to direct CalOptima Health to transmit the PHI directly to another person, or entity, as designated by the Member or their Personal Representative, in accordance with CalOptima Health Policy HH.3009: Access by Member's Personal Representative.

        i. The Member's or their Personal Representative's request to transmit the PHI to another person, or entity, must be in writing, signed by the Member or their Personal Representative, and clearly identify the designated person, or entity, and location (postal address) to send the PHI.

2. A Parent has access to an unemancipated child's Designated Record Set regardless of custody or which parent arranges and/or pays for healthcare services unless the parent's parental rights have been terminated by a court.

    a. Under California law, if a minor age twelve (12) years and older consents on his or her own behalf for the following services without parental consent, PHI related to these services cannot be released to the parent or the Member's Personal Representative without specific authorization from the minor Member:

        i. Pregnancy test, prenatal care, or birth control;

        ii. Testing or Treatment for sexual disease, including Human Immunodeficiency Virus (HIV);

        iii. Mental health Treatment or counseling;

        iv. Treatment for rape or sexual assault; and

        v. Alcohol or substance abuse Treatment.

3. CalOptima Health will restrict the circumstances of the use or disclosure of reproductive health care information if the disclosure may be related to a prohibited purpose. Any investigations against persons seeking, obtaining, providing, or facilitating lawful reproductive health care may be such circumstances.

4. While CalOptima Health's DRS contains certain medical and payment records from providers, it does not have complete copies of records created and/or maintained by Providers or entities other than CalOptima Health. If a Member wants such records, they are advised to contact their doctor, Health Network, or other health care Provider. CalOptima Health does maintain medical and billing records for PACE Program participants which may be obtained by the participant or their Personal Representative.

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5. CalOptima Health shall process a request to access, inspect or obtain copies of the PHI in the DRS promptly, and unless an extension is required under Section III.A.5., no later than thirty (30) calendar days after receipt of a complete written request. Electronic Patient Access APIs shall make information available in accordance with CMS interoperability implementation timelines independent of the HIPAA access request process.

    a. If the Member requests their PHI to be sent via mail, CalOptima Health may impose a reasonable, cost-based fee for postage and may charge up to ten cents ($0.10) per page for copying.

6. If necessary, a thirty (30) calendar day extension may be used to retrieve information that is not readily available.

    a. For an extension, CalOptima Health must provide the Member, within thirty (30) calendar days after receipt of the request, a written statement of the reasons for the delay and the date by which it will complete its action on the request.

    b. CalOptima Health may only have one (1) such extension of time for action on a request for access to DRS.

7. The Office of Compliance shall notify the Member, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this Policy.

8. Verification of Member identification requesting access to inspect or copy the DRS:

    a. If the Member makes such request in person to the Customer Service Department, Customer Service staff shall:

        i. Request identification (e.g., Driver License or Member ID card), or ask to verify the Member's date of birth or address based on FACETS™ data; and

        ii. Provide the Member with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D) for the Member to complete.

    b. If the Member request is received by mail or fax, the Office of Compliance staff shall verify the identity of the individual in accordance with CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information.

9. The Office of Compliance shall accept a request from the Member as valid, provided all information on the request is complete and accurate. All requests shall include:

    a. An Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D); or

    b. A written request that provides sufficient information, as necessary to identify the specific PHI sought; and
    c. Documentation that verifies the identity of the Member, in accordance with CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information.

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10. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access. Requests for electronic API access shall not require manual review except where permitted by law or necessary to address fraud, abuse, identity verification, or security concerns.

~~10.~~11. The Office of Compliance may deny Member access in the following circumstances:

a. Psychotherapy Notes;

b. PHI compiled in reasonable anticipation of, or for Use in, a civil, criminal, or administrative action, or proceeding;

c. A CalOptima Health PACE covered health care Provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of PHI, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate;

d. A Member's access to PHI created or obtained by a CalOptima Health PACE covered health care Provider in the course of research that includes Treatment may be temporarily suspended for as long as the research is in progress, provided that the Member has agreed to the denial of access when consenting to participate in the research that includes Treatment, and the covered health care Provider has informed the Member that the right of access will be reinstated upon completion of the research;

e. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

f. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the Member, or another person;

g. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

h. The Personal Representative requests for access, and a licensed health care professional has determined, in their professional judgment, that the provision of access to such Personal Representative is reasonably likely to cause substantial harm to the individual, or another person.

i. Limitations applicable to HIPAA right-of-access requests shall not restrict information required to be made available through Patient Access APIs unless expressly authorized by federal or state law.

~~11.~~12. If the denial is based on any of the reasons as stated in Section III.A.~~9~~ 11.f-h, a Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Health Privacy Officer at 505 City Parkway West, Orange, CA 92868. The licensed health care professional involved in the appeal cannot be the same person as the licensed health care professional who made the original denial decision.

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13. If the denial is based on any of the reasons as stated in Section III.A.~~9~~ 11.a-e, a Member is not entitled to request that the denial be reviewed.

~~12.~~14. The Office of Compliance shall route the request to the department(s), or business associate responsible for creating, or maintaining, the requested record(s).

~~13.~~15. The responsible department shall locate and send a copy of all requested PHI to the Office of Compliance within seven (7) calendar days of receiving the request.

~~14.~~16. The Business Associate shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

~~15.~~17. The Office of Compliance shall review all records for accuracy prior to providing the requested records to the Member or their Personal Representative.

B. The following departments within CalOptima Health shall maintain the content found in the DRS:

1. Customer Service;
2. Information Technology Services;
3. Claims Administration;
4. Utilization Management;
5. Case Management;
6. Pharmacy;
7. Grievance and Appeals Resolution Services;
8. Enrollment;
9. Multipurpose Senior Services Program (MSSP);
10. Long-Term Services and Supports (LTSS);
11. Population Health Management;
12. Behavioral Health; and
13. Program of All-Inclusive Care for the Elderly (PACE).

C. Department staff shall provide copies of all requested PHI. Department staff shall inform the Privacy Officer if there are records that require further evaluation to determine the appropriateness of Member access to inspect or copy PHI from the DRS.

D. The Privacy Officer shall consult with a licensed healthcare professional to determine the appropriateness of Member access to inspect or copy PHI from the DRS.

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1. Access to specific types of records may be denied based on the determination of the licensed healthcare professional, as provided by the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

E. If CalOptima Health does not maintain the PHI that is the subject of the Member's request for access, and CalOptima Health knows where the requested information is maintained, CalOptima Health shall inform the Member of the entity to whom the Member may direct such request.

F. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

a. Approved: If CalOptima Health approves the Member's request, CalOptima Health shall provide the Member with a records enclosed notification letter (Attachment H) and the records requested, in accordance with the format and method designated on the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D) within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

b. Denied: If CalOptima Health denies the Member's request, CalOptima Health shall send a notification letter to the Member within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a Member may complain to CalOptima Health, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima Health.

c. Approved or denied, in whole or in part: If CalOptima Health approves a portion of the Member's request and also denies portion of the request, CalOptima Health shall provide the Member with the records requested in accordance with Section III.F.1.a of this Policy. CalOptima Health shall also provide a letter informing the Member of the denial (Attachment E or F, whichever is applicable), in accordance with Section III.F.1.b of this Policy.

d. Invalid Request: If the request is unable to be processed due to missing information, CalOptima Health will notify the Member or their Personal Representative with an invalid request letter (Attachment G) as soon as possible but no later than within thirty (30) calendar days of receipt.

G. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the Member, for ten (10) years from the date of the release.

H. Designated Record Set Content

1. The content of CalOptima Health's DRS can be found in the Designated Record Set Matrix (Attachment A).

I. Patient Access API

1. CalOptima Health shall make available the ~~following individual level~~current CMS-required version of the United States Core Data for Interoperability (USCDI~~)~~), together with any

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additional data ~~that they maintain for dates of services on,~~required by federal or ~~after, January 1, 2016,~~DHCS interoperability requirements. available to the Member or their Personal Representative:

Type of Information	Time by Which Information Must be Accessible
Adjudicated claims data and cost data, including claims that may be appealed, were appealed, or in the process of appeal	Within one (1) business day after a claim is processed
Encounter data for capitated Providers	Within one (1) business day after receiving data from Providers
Clinical data, including diagnoses and related codes, and laboratory test results	Within one (1) business day after receiving data from Providers
Information about covered outpatient drugs as part of medical services, and updates to such information, including, costs to the Member, and preferred drug list information, if applicable	Within one (1) business day after the effective date of any such information or updates to such information

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A. Designated Record Set Matrix~~
~~B.~~A. ~~Instruction Sheet for CalOptima Health, Health Insurance Portability and Accountability Act (HIPAA) Authorization for Disclosure of Protected Health Information~~
~~C.~~A. Authorization for CalOptima Health to Disclose Protected Health Information (PHI) to Another Person or Entity
~~A. Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)~~
~~B.~~A. ~~Letter: Denial of Access Subject to Review~~
~~C.~~A. ~~Letter: Denial of Access Not Subject to Review~~
~~D.~~A. ~~Letter: Request Invalid~~
~~E.~~A. ~~Letter: Records Enclosed~~

~~V.~~I. ~~REFERENCE(S)~~

~~D.~~B. California Code, Family Code § 3025
~~E.~~C. California Code, Health & Safety Code §§ 123110(a), 123115(a)(1);
~~F.~~D. California Code, Civil Code §§ 56.10, 56.11
~~G.~~E. CalOptima Health Compliance Plan
~~H.~~F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~I.~~G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~J.~~H. CalOptima Health PACE Program Agreement
~~K.~~I. CalOptima Health Notice of Privacy Practices
~~L.~~J. CalOptima Health Policy IT.1202: Technical Safeguard – Data Controls
~~M.~~K. CalOptima Health Policy GG.1618: Member Request for Medical Records
~~N.~~L. CalOptima Health Policy HH.2022: Record Retention and Access

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~~O.~~M. CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information
~~P.~~N. CalOptima Health Policy HH.3004: Member Request to Amend Records
~~Q.~~O. CalOptima Health Policy HH.3009: Access by Member's Personal Representative
~~R.~~P. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
~~S.~~Q. CalOptima Health Privacy Program
~~T.~~R. CMS Interoperability Rule (85 FR 25510)
S. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).
~~U.~~T. Department of Healthcare Services (DHCS) All Plan Letter (APL) 26-008: Interoperability Final Rules, Including Prior Authorization Requirements (Supersedes APL 22-026~~: Interoperability and Patient Access Final Rule~~)
U. Designated Record Set Matrix
V. Instruction Sheet for CalOptima Health, Health Insurance Portability and Accountability Act (HIPAA) Authorization for Disclosure of Protected Health Information
W. Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)
X. Letter: Denial of Access-Subject to Review
Y. Letter: Denial of Access-Not Subject to Review
Z. Letter: Records Enclosed
AA. Letter: Request Invalid
~~V.~~BB. NCQA Standard ~~MED5~~MED4 Privacy and Confidentiality: Element A: Factor 2 – ~~2017~~2026
~~W.~~CC. Title 45, Code of Federal Regulations (C.F.R.), §164.501
~~X.~~DD. Title 45, Code of Federal (C.F.R), § 164.502 (5) (iii)
~~Y.~~EE. Title 45, Code of Federal Regulations (C.F.R.), §164.524
~~Z.~~FF. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)
~~AA.~~GG. Title 42 Code of Federal Regulations (CFR) Section 431.60

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/13/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted
01/29/2026	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/06/2025	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

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Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	12/01/2016	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2023	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE
Revised	10/01/2024	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2025	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE
Revised	01/01/2026	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE
Revised		HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Application Programming Interface (API)	A standardized set of technical specifications and protocols that allows separate software applications to securely communicate, exchange, and retrieve electronic health information without requiring direct access to another system's underlying database. For purposes of this policy, APIs include CMS-required Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs.
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care Provider; 2. The enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, Used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in Title 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
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.
Health Information Exchange (HIE)	An organization or technology platform that enables the secure electronic exchange of health information among participating health care organizations, health plans, public health agencies, and other authorized entities in accordance with applicable federal and state law.

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Term	Definition
Interoperability	The capability of different information systems, devices, applications, or organizations to securely access, exchange, integrate, and use electronic health information in a coordinated manner that supports clinical care, care coordination, payment, public health, and health care operations. Interoperability includes the use of nationally recognized technical standards adopted by CMS, ONC, DHCS, or other applicable regulatory authorities.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Member	An individual enrolled in a CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	A program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Patient Access API	The federally required standards-based API that enables Members to securely access their health information electronically using applications of their choice, consistent with applicable federal and state law. Information available through the Patient Access API includes, as applicable: • Claims; • Encounters; • Clinical information; • Laboratory results; • Provider directory information; • Prior authorization information; and • Other data required under CMS interoperability regulations.
Provider Access API	The CMS-required standards-based API that enables participating contracted Providers with a treatment relationship to electronically access Member health information necessary for treatment and care coordination, subject to applicable privacy and security requirements. Information exchanged shall be limited to data required under applicable CMS regulations and DHCS guidance.

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Term	Definition
Personal Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Protected Health Information (PHI)	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
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. 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.
Psychotherapy Notes	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. Notes recorded (in any medium) by a health care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Member's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date

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Term	Definition
Treatment	Has the meaning in 45 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3001
Title:	**Member Access to Designated Record Set**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy defines the Designated Record Set (DRS) that contains Protected Health Information (PHI) maintained by CalOptima Health and establishes the requirements under which a Member or Personal Representative may inspect, obtain, or electronically access PHI maintained in the DRS, including through standards-based Application Programming Interfaces (APIs), in accordance with the HIPAA Privacy Rule (45 CFR §164.524), 42 CFR §431.60, the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F), the Office of the National Coordinator for Health Information Technology (ONC) Cures Act Final Rule (45 CFR Part 171), and the Department of Health Care Services (DHCS) All Plan Letter (APL) 26-008: Interoperability Final Rules, Including Prior Authorization Requirements.

II. POLICY

A. Except as otherwise provided in Section III.A.11. of this Policy, Members shall have the right of access to inspect and obtain a copy of their PHI in the DRS for as long as CalOptima Health maintains the PHI in the DRS.

B. CalOptima Health shall provide a Member with access to their PHI in the format requested by the Member, if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by CalOptima Health and the Member.

C. CalOptima Health shall grant a Member's Personal Representative access to a Member's PHI, in accordance with CalOptima Health Policies HH.3009: Access by Member's Personal Representative and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

D. CalOptima Health shall implement, maintain, monitor, and secure standards-based APIs that allow Members and their Personal Representatives to electronically access health information required under federal interoperability regulations using Third-Party Applications selected by the Member. CalOptima Health shall implement and maintain a secure, standards-based Patient Access API that shall connect to provider electronic health records and practice management systems, in accordance with requirements specified at 42 CFR section 431.60, including claims data, encounter data, clinical data maintained by CalOptima Health, prior authorization information, covered outpatient drugs and other information required by CMS or DHCS. Electronic access through the Patient Access API shall

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be available independent of the HIPAA right-of-access process and shall not require submission of a written HIPAA access request.

1. CalOptima Health shall permit third-party applications, such as an API, to retrieve data specified in the Patient Access Rule, through the use of common technologies and without special effort from the Member, with the approval and the direction of a Member or Member's Personal Representative.

2. Technical safeguards, data protection controls, system testing, monitoring, and regulatory compliance requirements applicable to the Patient Access API are governed by CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls, and related Information Technology and Information Security policies.

E. CalOptima Health shall not engage in practices likely to interfere with, prevent, materially discourage, or delay lawful access, exchange, or use of electronic health information except as expressly permitted under federal regulations governing information blocking.

F. Any person with knowledge of a violation, or potential violation, of this Policy shall report such information to the Privacy Officer directly, or through the CalOptima Health Compliance and Ethics Hotline at 1-855-507-1805 or email: privacy@caloptimahealth.org.

G. Members may authorize any compliant third-party application to retrieve information through the Patient Access API. Prior to disclosure, CalOptima Health shall provide the Member with educational information explaining that once information is disclosed to a Third-Party Application that is not a HIPAA Covered Entity or Business Associate, HIPAA protections may no longer apply.

H. CalOptima Health shall maintain administrative, technical, and physical safeguards protecting Patient Access APIs including:

1. OAuth 2.0;

2. SMART on FHIR;

3. TLS encryption;

4. Audit logging;

5. Continuous monitoring;

6. Vulnerability management;

7. Token expiration;

8. Identity verification; and

9. Incident response procedures.

III. PROCEDURE

A. Requests for access to inspect or obtain a copy of DRS:

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1. A Member shall submit a written request for access to inspect or obtain a copy of their PHI in the DRS by submitting the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D) to the Office of Compliance. A Member's Personal Representative may request access to the Member's PHI in accordance with the requirements set forth in CalOptima Health Policy HH.3009: Access by Member's Personal Representative. This requirement does not apply to electronic access obtained through standards-based Patient Access APIs.

    a. Member or their Personal Representative has the right to direct CalOptima Health to transmit the PHI directly to another person, or entity, as designated by the Member or their Personal Representative, in accordance with CalOptima Health Policy HH.3009: Access by Member's Personal Representative.

        i. The Member's or their Personal Representative's request to transmit the PHI to another person, or entity, must be in writing, signed by the Member or their Personal Representative, and clearly identify the designated person, or entity, and location (postal address) to send the PHI.

2. A Parent has access to an unemancipated child's Designated Record Set regardless of custody or which parent arranges and/or pays for healthcare services unless the parent's parental rights have been terminated by a court.

    a. Under California law, if a minor age twelve (12) years and older consents on his or her own behalf for the following services without parental consent, PHI related to these services cannot be released to the parent or the Member's Personal Representative without specific authorization from the minor Member:

        i. Pregnancy test, prenatal care, or birth control;

        ii. Testing or Treatment for sexual disease, including Human Immunodeficiency Virus (HIV);

        iii. Mental health Treatment or counseling;

        iv. Treatment for rape or sexual assault; and

        v. Alcohol or substance abuse Treatment.

3. CalOptima Health will restrict the circumstances of the use or disclosure of reproductive health care information if the disclosure may be related to a prohibited purpose. Any investigations against persons seeking, obtaining, providing, or facilitating lawful reproductive health care may be such circumstances.

4. While CalOptima Health's DRS contains certain medical and payment records from providers, it does not have complete copies of records created and/or maintained by Providers or entities other than CalOptima Health. If a Member wants such records, they are advised to contact their doctor, Health Network, or other health care Provider. CalOptima Health does maintain medical and billing records for PACE Program participants which may be obtained by the participant or their Personal Representative.

5. CalOptima Health shall process a request to access, inspect or obtain copies of the PHI in the DRS promptly, and unless an extension is required under Section III.A.5., no later than thirty (30)

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calendar days after receipt of a complete written request. Electronic Patient Access APIs shall make information available in accordance with CMS interoperability implementation timelines independent of the HIPAA access request process.

a. If the Member requests their PHI to be sent via mail, CalOptima Health may impose a reasonable, cost-based fee for postage and may charge up to ten cents ($0.10) per page for copying.

6. If necessary, a thirty (30) calendar day extension may be used to retrieve information that is not readily available.

a. For an extension, CalOptima Health must provide the Member, within thirty (30) calendar days after receipt of the request, a written statement of the reasons for the delay and the date by which it will complete its action on the request.

b. CalOptima Health may only have one (1) such extension of time for action on a request for access to DRS.

7. The Office of Compliance shall notify the Member, in writing, of the determination on the request. The notice shall contain the information set forth in Section III.E. of this Policy.

8. Verification of Member identification requesting access to inspect or copy the DRS:

a. If the Member makes such request in person to the Customer Service Department, Customer Service staff shall:

i. Request identification (e.g., Driver License or Member ID card), or ask to verify the Member's date of birth or address based on FACETS™ data; and

ii. Provide the Member with a copy of the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D) for the Member to complete.

b. If the Member request is received by mail or fax, the Office of Compliance staff shall verify the identity of the individual in accordance with CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information.

9. The Office of Compliance shall accept a request from the Member as valid, provided all information on the request is complete and accurate. All requests shall include:

a. An Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D); or

b. A written request that provides sufficient information, as necessary to identify the specific PHI sought; and

c. Documentation that verifies the identity of the Member, in accordance with CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information.

10. The Office of Compliance shall review the request, determine if Member access is appropriate, and which parts of the DRS the Member cannot access. Requests for electronic API access shall

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not require manual review except where permitted by law or necessary to address fraud, abuse, identity verification, or security concerns.

11. The Office of Compliance may deny Member access in the following circumstances:

    a. Psychotherapy Notes;

    b. PHI compiled in reasonable anticipation of, or for Use in, a civil, criminal, or administrative action, or proceeding;

    c. A CalOptima Health PACE covered health care Provider acting under the direction of the correctional institution may deny, in whole or in part, an inmate's request to obtain a copy of PHI, if obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting of the inmate;

    d. A Member's access to PHI created or obtained by a CalOptima Health PACE covered health care Provider in the course of research that includes Treatment may be temporarily suspended for as long as the research is in progress, provided that the Member has agreed to the denial of access when consenting to participate in the research that includes Treatment, and the covered health care Provider has informed the Member that the right of access will be reinstated upon completion of the research;

    e. PHI obtained from someone other than a Provider under a promise of confidentiality, and the access requested would be reasonably likely to reveal the source of the information.

    f. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life, or physical safety, of the Member, or another person;

    g. The PHI makes reference to another person other than the Member, unless that person is a Provider, and a licensed health care professional has determined, in his or her professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or

    h. The Personal Representative requests for access, and a licensed health care professional has determined, in their professional judgment, that the provision of access to such Personal Representative is reasonably likely to cause substantial harm to the individual, or another person.

    i. Limitations applicable to HIPAA right-of-access requests shall not restrict information required to be made available through Patient Access APIs unless expressly authorized by federal or state law.

12. If the denial is based on any of the reasons as stated in Section III.A.11.f-h, a Member can request to have the denial reviewed by another licensed health care professional by submitting a written request to the CalOptima Health Privacy Officer at 505 City Parkway West, Orange, CA 92868. The licensed health care professional involved in the appeal cannot be the same person as the licensed health care professional who made the original denial decision.

13. If the denial is based on any of the reasons as stated in Section III.A.11.a-e, a Member is not entitled to request that the denial be reviewed.

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14. The Office of Compliance shall route the request to the department(s), or business associate responsible for creating, or maintaining, the requested record(s).

15. The responsible department shall locate and send a copy of all requested PHI to the Office of Compliance within seven (7) calendar days of receiving the request.

16. The Business Associate shall send a copy of the requested PHI to the Office of Compliance within fourteen (14) calendar days of receiving the request.

17. The Office of Compliance shall review all records for accuracy prior to providing the requested records to the Member or their Personal Representative.

B. The following departments within CalOptima Health shall maintain the content found in the DRS:

1. Customer Service;

2. Information Technology Services;

3. Claims Administration;

4. Utilization Management;

5. Case Management;

6. Pharmacy;

7. Grievance and Appeals Resolution Services;

8. Enrollment;

9. Multipurpose Senior Services Program (MSSP);

10. Long-Term Services and Supports (LTSS);

11. Population Health Management;

12. Behavioral Health; and

13. Program of All-Inclusive Care for the Elderly (PACE).

C. Department staff shall provide copies of all requested PHI. Department staff shall inform the Privacy Officer if there are records that require further evaluation to determine the appropriateness of Member access to inspect or copy PHI from the DRS.

D. The Privacy Officer shall consult with a licensed healthcare professional to determine the appropriateness of Member access to inspect or copy PHI from the DRS.

1. Access to specific types of records may be denied based on the determination of the licensed healthcare professional, as provided by the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

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E. If CalOptima Health does not maintain the PHI that is the subject of the Member's request for access, and CalOptima Health knows where the requested information is maintained, CalOptima Health shall inform the Member of the entity to whom the Member may direct such request.

F. Notification to Member:

1. The Office of Compliance shall notify the Member regarding the record request as follows:

a. Approved: If CalOptima Health approves the Member's request, CalOptima Health shall provide the Member with a records enclosed notification letter (Attachment H) and the records requested, in accordance with the format and method designated on the Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS) Form (Attachment D) within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed.

b. Denied: If CalOptima Health denies the Member's request, CalOptima Health shall send a notification letter to the Member within thirty (30) calendar days after receipt of the request, but no later than sixty (60) calendar days if an extension is needed, informing the Member of the decision, the reason for denial, and instructions on Member's appeal rights to have the materials reviewed, if applicable. The denial notice shall include a description of how a Member may complain to CalOptima Health, or the Office of Civil Rights (OCR), and contact information for how to file a complaint with CalOptima Health.

c. Approved or denied, in whole or in part: If CalOptima Health approves a portion of the Member's request and also denies portion of the request, CalOptima Health shall provide the Member with the records requested in accordance with Section III.F.1.a of this Policy. CalOptima Health shall also provide a letter informing the Member of the denial (Attachment E or F, whichever is applicable), in accordance with Section III.F.1.b of this Policy.

d. Invalid Request: If the request is unable to be processed due to missing information, CalOptima Health will notify the Member or their Personal Representative with an invalid request letter (Attachment G) as soon as possible but no later than within thirty (30) calendar days of receipt.

G. Documentation

1. The Office of Compliance shall retain a record of the requests and related letters, including a copy of information released to the Member, for ten (10) years from the date of the release.

H. Designated Record Set Content

1. The content of CalOptima Health's DRS can be found in the Designated Record Set Matrix (Attachment A).

I. Patient Access API

1. CalOptima Health shall make available the current CMS-required version of the United States Core Data for Interoperability (USCDI), together with any additional data required by federal or DHCS interoperability requirements. available to the Member or their Personal Representative:

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Type of Information	Time by Which Information Must be Accessible
Adjudicated claims data and cost data, including claims that may be appealed, were appealed, or in the process of appeal	Within one (1) business day after a claim is processed
Encounter data for capitated Providers	Within one (1) business day after receiving data from Providers
Clinical data, including diagnoses and related codes, and laboratory test results	Within one (1) business day after receiving data from Providers
Information about covered outpatient drugs as part of medical services, and updates to such information, including, costs to the Member, and preferred drug list information, if applicable	Within one (1) business day after the effective date of any such information or updates to such information

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Authorization for CalOptima Health to Disclose Protected Health Information (PHI) to Another Person or Entity
B. California Code, Family Code § 3025
C. California Code, Health & Safety Code §§ 123110(a), 123115(a)(1);
D. California Code, Civil Code §§ 56.10, 56.11
E. CalOptima Health Compliance Plan
F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
H. CalOptima Health PACE Program Agreement
I. CalOptima Health Notice of Privacy Practices
J. CalOptima Health Policy IT.1202: Technical Safeguard – Data Controls
K. CalOptima Health Policy GG.1618: Member Request for Medical Records
L. CalOptima Health Policy HH.2022: Record Retention and Access
M. CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information
N. CalOptima Health Policy HH.3004: Member Request to Amend Records
O. CalOptima Health Policy HH.3009: Access by Member's Personal Representative
P. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)
Q. CalOptima Health Privacy Program
R. CMS Interoperability Rule (85 FR 25510)
S. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).
T. Department of Healthcare Services (DHCS) All Plan Letter (APL) 26-008: Interoperability Final Rules, Including Prior Authorization Requirements (Supersedes APL 22-026)
U. Designated Record Set Matrix
V. Instruction Sheet for CalOptima Health, Health Insurance Portability and Accountability Act (HIPAA) Authorization for Disclosure of Protected Health Information
W. Individual Request for Access to Protected Health Information (PHI) Contained in the Designated Record Set (DRS)

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X. Letter: Denial of Access-Subject to Review
Y. Letter: Denial of Access-Not Subject to Review
Z. Letter: Records Enclosed
AA. Letter: Request Invalid
BB. NCQA Standard MED4 Privacy and Confidentiality: Element A: Factor 2 – 2026
CC. Title 45, Code of Federal Regulations (C.F.R.), §164.501
DD. Title 45, Code of Federal (C.F.R), § 164.502 (5) (iii)
EE. Title 45, Code of Federal Regulations (C.F.R.), §164.524
FF. Title 45, Code of Federal Regulations (C.F.R.), §164.530(j)(2)
GG. Title 42 Code of Federal Regulations (CFR) Section 431.60

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/13/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted
01/29/2026	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/06/2025	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	04/01/2007	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2008	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	07/01/2011	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2013	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	01/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	11/01/2014	HH.3001	Member Access to Designated Record Set	Medi-Cal
Revised	09/01/2015	HH.3001	Member Access to Designated Record Set	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2017	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare OneCare Connect PACE
Revised	03/01/2023	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE
Revised	10/01/2024	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE
Revised	11/01/2025	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE
Revised	01/01/2026	HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE
Revised		HH.3001	Member Access to Designated Record Set	Medi-Cal OneCare PACE

E

IX. GLOSSARY

Term	Definition
Application Programming Interface (API)	A standardized set of technical specifications and protocols that allows separate software applications to securely communicate, exchange, and retrieve electronic health information without requiring direct access to another system's underlying database. For purposes of this policy, APIs include CMS-required Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs.
Designated Record Set (DRS)	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. A group of records maintained by or for a covered entity that is: 1. The medical records and billing records about individuals maintained by or for a covered health care Provider; 2. The enrollment, Payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or 3. Used, in whole or in part, by or for the covered entity to make decisions about individuals. The term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, Used, or disseminated by or for a covered entity.
Disclosure	Has the meaning in Title 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
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.
Health Information Exchange (HIE)	An organization or technology platform that enables the secure electronic exchange of health information among participating health care organizations, health plans, public health agencies, and other authorized entities in accordance with applicable federal and state law.

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Term	Definition
Interoperability	The capability of different information systems, devices, applications, or organizations to securely access, exchange, integrate, and use electronic health information in a coordinated manner that supports clinical care, care coordination, payment, public health, and health care operations. Interoperability includes the use of nationally recognized technical standards adopted by CMS, ONC, DHCS, or other applicable regulatory authorities.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California WIC Section 14186.1, Medi-Cal covered LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled nursing facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Member	An individual enrolled in a CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	A program approved under the federal Medicaid Home and Community-Based, 1915 (c) Waiver designed to prevent premature institutionalization through provision of comprehensive social and health care management to assist frail elder person who are certifiable for placement in a nursing facility, to remain safely at home at a cost lower than nursing facility care.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Patient Access API	The federally required standards-based API that enables Members to securely access their health information electronically using applications of their choice, consistent with applicable federal and state law. Information available through the Patient Access API includes, as applicable: • Claims; • Encounters; • Clinical information; • Laboratory results; • Provider directory information; • Prior authorization information; and • Other data required under CMS interoperability regulations.
Provider Access API	The CMS-required standards-based API that enables participating contracted Providers with a treatment relationship to electronically access Member health information necessary for treatment and care coordination, subject to applicable privacy and security requirements. Information exchanged shall be limited to data required under applicable CMS regulations and DHCS guidance.

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Term	Definition
Personal Representative	Has the meaning given to the term Personal Representative in Section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Protected Health Information (PHI)	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
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. 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.
Psychotherapy Notes	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations. Notes recorded (in any medium) by a health care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the Member's medical record. Psychotherapy Notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date

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Term	Definition
Treatment	Has the meaning in 45 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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For 20261105 BOD Review Only

Policy:	HH.3014
Title:	**Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	
Applicable to:	☐ Administrative ☒~~☐~~ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy describes CalOptima Health's procedures related to the Use of electronic mail (email) to send information containing Protected Health Information (PHI) and Personally Identifiable Information (PII).

II. POLICY

A. CalOptima Health, its Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall send email containing PHI/PII as follows:

1. Internal email

   a. Email sent within CalOptima Health's mail system may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls.

   b. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email. Emails should be reviewed prior to sending and responding to ensure no PHI/PII is included in the email subject line. Employees must remove PHI/PII from the email subject line and revise before sending a reply or forwarding the email.

2. External email sent on the Internet

   a. Email that CalOptima Health or a Business Associate sends to an external entity via the open Internet shall not contain PHI/PII unless the email, or attachment, has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

   b. Email that CalOptima Health or a Business Associate sends to an outside entity may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

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c. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email. Emails should be reviewed prior to sending and responding to ensure no PHI/PII is included in the email subject line. Employees must remove PHI/PII from the email subject line and revise before sending a reply or forwarding the email.

B. CalOptima Health staff shall appropriately use information and Information Technology (IT) resources and security of those resources when performing procedures related to the Use of email to send information containing PHI/PII, in accordance with CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources.

C. CalOptima Health staff shall follow instructions for Use of email, as set forth in CalOptima Health Policy GA.5005b: Email and Internet Use.

III. PROCEDURE

A. Communications via email sent through the open Internet requires Encryption to prevent unauthorized access to PHI/PII, in accordance with CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls. CalOptima Health employees shall encrypt external emails by utilizing Microsoft Outlook Send Secure encryption, Transport Layer Security (TLS) encryption technology, or other encryption technologies established by IT.

B. CalOptima Health employees and Business Associates shall immediately report any suspected or known Security Incidents, Breach, and/or other unauthorized access, Use or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

C. CalOptima Health employees shall not save or store data files in an electronic format that contain PHI/PII on public or private computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts, in accordance with CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
F. CalOptima Health Policy GA.5005b: E-mail and Internet Use
G. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls
H. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site

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I. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII
J. CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/17/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2011	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/07/2017	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE
Revised	11/01/2025	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE
Revised		HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Covered California Medi-Cal OneCare PACE

For

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The Use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without Use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
First Tier, Downstream and Related Entities (FDR)	For purposes of this policy, FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Health Network	For purposes of this policy, the contracted Health Networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary enrolled in a CalOptima Health Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PII	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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For 20261105 BOD Review Only

Policy:	HH.3014
Title:	**Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy describes CalOptima Health's procedures related to the Use of electronic mail (email) to send information containing Protected Health Information (PHI) and Personally Identifiable Information (PII).

II. POLICY

A. CalOptima Health, its Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall send email containing PHI/PII as follows:

1. Internal email

   a. Email sent within CalOptima Health's mail system may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls.

   b. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email. Emails should be reviewed prior to sending and responding to ensure no PHI/PII is included in the email subject line. Employees must remove PHI/PII from the email subject line and revise before sending a reply or forwarding the email.

2. External email sent on the Internet

   a. Email that CalOptima Health or a Business Associate sends to an external entity via the open Internet shall not contain PHI/PII unless the email, or attachment, has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

   b. Email that CalOptima Health or a Business Associate sends to an outside entity may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

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c. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email. Emails should be reviewed prior to sending and responding to ensure no PHI/PII is included in the email subject line. Employees must remove PHI/PII from the email subject line and revise before sending a reply or forwarding the email.

B. CalOptima Health staff shall appropriately use information and Information Technology (IT) resources and security of those resources when performing procedures related to the Use of email to send information containing PHI/PII, in accordance with CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources.

C. CalOptima Health staff shall follow instructions for Use of email, as set forth in CalOptima Health Policy GA.5005b: Email and Internet Use.

III. PROCEDURE

A. Communications via email sent through the open Internet requires Encryption to prevent unauthorized access to PHI/PII, in accordance with CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls. CalOptima Health employees shall encrypt external emails by utilizing Microsoft Outlook Send Secure encryption, Transport Layer Security (TLS) encryption technology, or other encryption technologies established by IT.

B. CalOptima Health employees and Business Associates shall immediately report any suspected or known Security Incidents, Breach, and/or other unauthorized access, Use or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

C. CalOptima Health employees shall not save or store data files in an electronic format that contain PHI/PII on public or private computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts, in accordance with CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
F. CalOptima Health Policy GA.5005b: E-mail and Internet Use
G. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls
H. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site

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I. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII
J. CalOptima Health Policy IT.1202: Technical Safeguards – Data Controls

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/17/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2011	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/07/2017	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE
Revised	11/01/2025	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE
Revised		HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Covered California Medi-Cal OneCare PACE

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For

IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The Use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without Use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
First Tier, Downstream and Related Entities (FDR)	For purposes of this policy, FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Health Network	For purposes of this policy, the contracted Health Networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary enrolled in a CalOptima Health Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

For 2026 10: BOD Review Only

Term	Definition
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PII	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3015
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	
Applicable to:	☐ Administrative ~~☐~~☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy describes the circumstances and process for obtaining a Member's (or their Personal Representative's) Authorization for the Use and Disclosure of a Member's Protected Health Information (PHI).

II. POLICY

A. CalOptima Health shall only Use or Disclose a Member's PHI pursuant to a written Authorization from the Member, or the Member's Personal Representative, unless otherwise permitted, or required, by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state laws.

B. CalOptima Health will not condition Treatment, Payment, enrollment, or benefits eligibility on an individual granting an Authorization.

C. CalOptima Health shall obtain, review, and confirm that it has a valid Authorization from the Member, or the Member's Personal Representative, in accordance with HIPAA, other applicable federal and state laws, and this policy prior to a Use or Disclosure of PHI that requires an Authorization.

D. CalOptima Health may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment and Health Care Operations as permitted by HIPAA and other applicable federal and state laws pursuant to CalOptima Health Policies HH.3010 Protected Health Information Disclosures required by Law and HH.3011: Use and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

E. Uses and Disclosures involving Member PHI that has been properly De-Identified, pursuant to the requirements in Title 45, Code of Federal Regulations, Section 164.514, do not require a Member's Authorization.

III. PROCEDURE

Back to Agenda Back to Item

A. All valid Authorizations shall contain specified core elements and requirements, in accordance with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil Code, Section 56.11. A completed CalOptima Health Authorization Form for Disclosure of PHI must include the following required elements in compliance with Title 45, Code of Federal Regulations, Section 164.508(c) and California Civil Code, Section 56.11:

1. Be handwritten by the person who signs it or is typed in a typeface no smaller than fourteen (14) point font;

2. A description of the information to be Used or Disclosed;

3. The name of the person or organization that will Use or Disclose the PHI;

4. The name of the person or organization that will receive the PHI;

5. Identifies the Uses and limitations on Uses for which the PHI will be disclosed (except for requests by a Member, which can indicate "at Member's request" without further explanation);

6. The specific expiration date or expiration event;

7. Includes the Member's or their Personal Representative's signature and the date. If the Authorization is signed by a Member's Personal Representative, a description of such representative's authority to act for the Member must also be provided. (*e.g.,* parent, power of attorney for health care, court-appointed guardian, etc.); and

8. In addition to the requirements above, the following statements must also be included in the Authorization;

   a. A statement that the Member has the right to revoke the Authorization, in writing, and any exceptions to this right;

   b. A statement that CalOptima Health will not condition Treatment, or Payment, on the Member signing the Authorization request;

   c. A statement informing the Member about the potential for information to be redisclosed and no longer protected by the state or federal privacy rule;

   d. A statement that the Member can refuse to sign the Authorization;

   e. A statement that the Member is entitled to a copy of the signed Authorization. A copy of the signed Authorization must be given to the Member; or

   f. A statement when any Disclosure will result in either direct, or indirect, Payment to CalOptima Health from the receiver of the PHI.

B. All Uses and Disclosures made pursuant to an Authorization must be consistent with the Authorization.

C. An Authorization shall be considered invalid if the document submitted contains any of the following defects:

1. The expiration date has passed;

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2. The Authorization does not contain all the required elements;

3. The Authorization is known by CalOptima Health to have been revoked;

4. The Authorization is combined with any other document in a manner that is not permitted under the privacy standard;

5. The signature serves some purpose in addition to the Authorization to disclose PHI; or

6. The Authorization contains material information known by CalOptima Health to be false.

D. Authorized Representative Designation for Appeals and Grievances

1. A Member may designate an Authorized Representative to act on the Member's behalf in the Grievance and Appeal Process. CalOptima Health shall recognize the designation upon receipt and review of the Member's written consent or documentation establishing the authority of the Member's legally authorized Personal Representative, as applicable. Within the scope of a valid designation, an Authorized Representative may:

   a. Submit and pursue Grievances, Appeals, and related requests on the Member's behalf;

   b. Receive communications and correspondence related to the Grievance or Appeal;

   c. Participate in activities related to the review and resolution of Grievance or Appeal; and

   d. Receive or discuss Protected health Information reasonably necessary to represent the Member in the Grievance and Appeal Process, consistent with applicable law and the scope of the designation.

2. A Member , or legally authorized Personal Representative acting within the scope of their authority, shall complete and submit the Appeal and Grievance Authorized Representative Designation Form to designate an Authorized Representative. CalOptima Health may request documentation necessary to verify the Personal Representative's legal authority.

3. The CalOptima Health Grievance and Appeals Department, consulting with the CalOptima Privacy Department as applicable, shall review the completed designation form and any supporting documentation for completeness and validity. Once accepted, the Grievance and Appeals Department shall document the designation in the Member's record and retain the form in accordance with applicable record-retention requirements.

4. An Authorized Representative Designation is effective on the date signed, unless another effective date is specified, and remains valid for one (1) year unless:

   a. The Member or legally authorized Personal Representative specifies a shorter period;

   b. The designation is revoked in accordance with CalOptima Health procedures;

   c. The Personal Representative's legal authority ends or is otherwise limited.

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5. For an active Grievance or Appeal initiated during the designation period; the designation should remain effective through final resolution of that matter unless revoked or otherwise limited.

~~D.~~E. CalOptima Health staff shall verify the identity of the Personal Representative, in accordance with CalOptima Health Policy HH.3003: Verification of Identity for Disclosures of Protected Health Information.

~~E.~~F. Revocation of Authorization

1. A Member may revoke an Authorization at any time by submitting the Revocation of Authorization for Release of Protected Health Information Form to CalOptima Health and requesting that the Authorization be revoked.

2. The revocation will not apply to those Uses or Disclosures made in reliance on the Authorization prior to CalOptima Health receiving the request to revoke the Authorization.

G. All signed Authorization and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima Health.

H. CalOptima Health shall mail a HIPAA Authorization for Disclosure of Information Form to Members requesting Disclosure of PHI when such form is required by HIPAA privacy regulations.

1. Upon receipt of signed and completed form via fax, or mail, the CalOptima Health Privacy Officer, or designee, shall review, approve, or deny, and disclose requested information when appropriate, per the signed form.

I. CalOptima Health shall obtain Authorization from the Member for any Use or Disclosure of psychotherapy notes except in the situations listed below. If a Member authorizes a Use or Disclosure of psychotherapy notes in addition to other PHI, CalOptima Health will obtain a separate Authorization for disclosure of psychotherapy notes only. CalOptima Health will not obtain Authorization for a Use or Disclosure of psychotherapy notes in the following situations:

1. Use by the originator of the psychotherapy notes for Treatment;

2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. Use by a Provider for purposes of diagnosis, or Treatment, of the Member;

4. Use or Disclosure by a covered entity to defend itself in a legal action, or other proceeding, brought by the Member; or

5. Evaluation, or oversight, of the practitioner creating the psychotherapy notes.

J. CalOptima Health shall obtain Authorization from the Member for any Use or Disclosure of Substance Use Disorder information.

K. CalOptima Health shall obtain Authorization from the Member for any Use or Disclosure of Sensitive Services information.

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L. CalOptima Health shall obtain Authorization from the Member for the designation of an Authorized Representative for the Appeal and Grievance Process in instances where a member does not have a personal representative but is designating an individual or agency for such purposes. The authorization for the Appeal and Grievance Process refers to the submission of Appeals and Grievances, receipt of communication and correspondence, access to relevant protected health information (PHI), and participation in activities related to the review and resolution of Appeals and Grievances.

~~L.~~M. Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:

1. Face-to-face communication is made by CalOptima Health to the Member; or

2. The communication is in the form of a promotional gift of nominal value provided by CalOptima Health.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Appeals and Grievance Authorized Representative Designation Form
~~A.~~B. Authorization for CalOptima Health to Disclose Protected Health Information (PHI) to Another Person or Entity
~~B. Instruction Sheet for CalOptima Health, Health Insurance Portability and Accountability Act (HIPAA) Authorization for Disclosure of Protected Health Information (PHI)~~
~~C. HIPAA Authorization Checklist~~
~~D. Revocation of Authorization for Release of Protected Health Information (PHI)~~

~~V.I. REFERENCE(S)~~

~~A.~~C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.~~D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C.~~E. CalOptima Health PACE Program Agreement
~~D.~~F. CalOptima Health Compliance Plan
~~E.~~G. CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information
~~F.~~H. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information
~~G.~~I. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
J. California Civil Code, §§56.10(c), 56.11(b) and 56.104
K. Health Insurance Portability and Accountability Act (HIPAA) Authorization Checklist
L. Instruction Sheet for CalOptima Health, HIPAA Disclosure of Protected Health Information (PHI)
~~H.~~M. NCQA Standard MED5 Privacy and Confidentiality: Factor B – 2017
N. Revocation of Authorization for Release of PHI
~~I. A. California Civil Code, §§56.10(c), 56.11(b) and 56.104~~
~~J.~~O. Title 22, Code of California Regulations (C.C.R.), §51009
~~K.~~P. Title 42, Code of Federal Regulations (C.F.R.), Part 2

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~~L.~~Q. Title 45, Code of Federal Regulations (C.F.R.), §§164.502(a)(iv), 164.506(a), and 164.508, 164.512

~~M.~~R. Welfare & Institutions Code, §14100.2

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/06/2025	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	04/01/2007	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2008	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2010	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2011	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2013	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	11/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	09/01/2015	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	12/01/2016	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Reviewed	05/01/2017	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

Preview Only

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised	10/01/2024	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised	11/01/2025	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised		HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Covered California Medi-Cal OneCare PACE

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For 2026

IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorization	Has the meaning given such term in 45 CFR § 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI, *e.g.*, Welfare & Institution Code § 14100.2.
De-Identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be Used to identify a Member.
Disclosure	Has the meaning given such term in 45 CFR § 160.103 including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Grievance	Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A Complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Grievance and Appeals Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances and Appeals.
Health Care Operations	Has the meaning given such term in 45 CFR § 164.501 including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

For 2026 1/05 BOD Review Only

Term	Definition
Marketing	Medi-Cal: Any activity conducted by or on behalf of CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade or influence eligible beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima Health. OneCare: Activities and use of materials that are conducted by CalOptima Health with the intent to draw a beneficiary's attention to CalOptima Health and to influence a beneficiary's decision- making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about CalOptima Health's benefit structure, cost sharing, measuring or ranking standards. PACE: Any activity conducted by or on behalf of CalOptima Health PACE where information regarding the services offered by CalOptima Health PACE is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima Health PACE.
Member	A beneficiary enrolled in a CalOptima Health Program.
Payment	Activities carried out by CalOptima Health including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-Authorization, concurrent, or retrospective review of services.
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
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 Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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For 20261105 BOD Review Only

Policy:	HH.3015
Title:	**Member Authorization for the Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy describes the circumstances and process for obtaining a Member's (or their Personal Representative's) Authorization for the Use and Disclosure of a Member's Protected Health Information (PHI).

II. POLICY

A. CalOptima Health shall only Use or Disclose a Member's PHI pursuant to a written Authorization from the Member, or the Member's Personal Representative, unless otherwise permitted, or required, by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state laws.

B. CalOptima Health will not condition Treatment, Payment, enrollment, or benefits eligibility on an individual granting an Authorization.

C. CalOptima Health shall obtain, review, and confirm that it has a valid Authorization from the Member, or the Member's Personal Representative, in accordance with HIPAA, other applicable federal and state laws, and this policy prior to a Use or Disclosure of PHI that requires an Authorization.

D. CalOptima Health may Use and Disclose a Member's PHI without a Member's Authorization for Treatment, Payment and Health Care Operations as permitted by HIPAA and other applicable federal and state laws pursuant to CalOptima Health Policies HH.3010 Protected Health Information Disclosures required by Law and HH.3011: Use and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations.

E. Uses and Disclosures involving Member PHI that has been properly De-Identified, pursuant to the requirements in Title 45, Code of Federal Regulations, Section 164.514, do not require a Member's Authorization.

III. PROCEDURE

Back to Agenda Back to Item

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1. Be handwritten by the person who signs it or is typed in a typeface no smaller than fourteen (14) point font;

2. A description of the information to be Used or Disclosed;

3. The name of the person or organization that will Use or Disclose the PHI;

4. The name of the person or organization that will receive the PHI;

5. Identifies the Uses and limitations on Uses for which the PHI will be disclosed (except for requests by a Member, which can indicate "at Member's request" without further explanation);

6. The specific expiration date or expiration event;

7. Includes the Member's or their Personal Representative's signature and the date. If the Authorization is signed by a Member's Personal Representative, a description of such representative's authority to act for the Member must also be provided. (*e.g.,* parent, power of attorney for health care, court-appointed guardian, etc.); and

8. In addition to the requirements above, the following statements must also be included in the Authorization;

   a. A statement that the Member has the right to revoke the Authorization, in writing, and any exceptions to this right;

   b. A statement that CalOptima Health will not condition Treatment, or Payment, on the Member signing the Authorization request;

   c. A statement informing the Member about the potential for information to be redisclosed and no longer protected by the state or federal privacy rule;

   d. A statement that the Member can refuse to sign the Authorization;

   e. A statement that the Member is entitled to a copy of the signed Authorization. A copy of the signed Authorization must be given to the Member; or

   f. A statement when any Disclosure will result in either direct, or indirect, Payment to CalOptima Health from the receiver of the PHI.

B. All Uses and Disclosures made pursuant to an Authorization must be consistent with the Authorization.

C. An Authorization shall be considered invalid if the document submitted contains any of the following defects:

1. The expiration date has passed;

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2. The Authorization does not contain all the required elements;

3. The Authorization is known by CalOptima Health to have been revoked;

4. The Authorization is combined with any other document in a manner that is not permitted under the privacy standard;

5. The signature serves some purpose in addition to the Authorization to disclose PHI; or

6. The Authorization contains material information known by CalOptima Health to be false.

D. Authorized Representative Designation for Appeals and Grievances

1. A Member may designate an Authorized Representative to act on the Member's behalf in the Grievance and Appeal Process. CalOptima Health shall recognize the designation upon receipt and review of the Member's written consent or documentation establishing the authority of the Member's legally authorized Personal Representative, as applicable. Within the scope of a valid designation, an Authorized Representative may:

   a. Submit and pursue Grievances, Appeals, and related requests on the Member's behalf;

   b. Receive communications and correspondence related to the Grievance or Appeal;

   c. Participate in activities related to the review and resolution of Grievance or Appeal; and

   d. Receive or discuss Protected health Information reasonably necessary to represent the Member in the Grievance and Appeal Process, consistent with applicable law and the scope of the designation.

2. A Member , or legally authorized Personal Representative acting within the scope of their authority, shall complete and submit the Appeal and Grievance Authorized Representative Designation Form to designate an Authorized Representative. CalOptima Health may request documentation necessary to verify the Personal Representative's legal authority.

3. The CalOptima Health Grievance and Appeals Department, consulting with the CalOptima Privacy Department as applicable, shall review the completed designation form and any supporting documentation for completeness and validity. Once accepted, the Grievance and Appeals Department shall document the designation in the Member's record and retain the form in accordance with applicable record-retention requirements.

4. An Authorized Representative Designation is effective on the date signed, unless another effective date is specified, and remains valid for one (1) year unless:

   a. The Member or legally authorized Personal Representative specifies a shorter period;

   b. The designation is revoked in accordance with CalOptima Health procedures;

   c. The Personal Representative's legal authority ends or is otherwise limited.

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5. For an active Grievance or Appeal initiated during the designation period; the designation should remain effective through final resolution of that matter unless revoked or otherwise limited.

E. CalOptima Health staff shall verify the identity of the Personal Representative, in accordance with CalOptima Health Policy HH.3003: Verification of Identity for Disclosures of Protected Health Information.

F. Revocation of Authorization

1. A Member may revoke an Authorization at any time by submitting the Revocation of Authorization for Release of Protected Health Information Form to CalOptima Health and requesting that the Authorization be revoked.

2. The revocation will not apply to those Uses or Disclosures made in reliance on the Authorization prior to CalOptima Health receiving the request to revoke the Authorization.

G. All signed Authorization and revocation notices are retained on file for ten (10) years from the date the documents are received by CalOptima Health.

H. CalOptima Health shall mail a HIPAA Authorization for Disclosure of Information Form to Members requesting Disclosure of PHI when such form is required by HIPAA privacy regulations.

1. Upon receipt of signed and completed form via fax, or mail, the CalOptima Health Privacy Officer, or designee, shall review, approve, or deny, and disclose requested information when appropriate, per the signed form.

I. CalOptima Health shall obtain Authorization from the Member for any Use or Disclosure of psychotherapy notes except in the situations listed below. If a Member authorizes a Use or Disclosure of psychotherapy notes in addition to other PHI, CalOptima Health will obtain a separate Authorization for disclosure of psychotherapy notes only. CalOptima Health will not obtain Authorization for a Use or Disclosure of psychotherapy notes in the following situations:

1. Use by the originator of the psychotherapy notes for Treatment;

2. Use or Disclosure by a covered entity's own training program for students, trainees, or practitioners in mental health, under supervision, to improve skills;

3. Use by a Provider for purposes of diagnosis, or Treatment, of the Member;

4. Use or Disclosure by a covered entity to defend itself in a legal action, or other proceeding, brought by the Member; or

5. Evaluation, or oversight, of the practitioner creating the psychotherapy notes.

J. CalOptima Health shall obtain Authorization from the Member for any Use or Disclosure of Substance Use Disorder information.

K. CalOptima Health shall obtain Authorization from the Member for any Use or Disclosure of Sensitive Services information.

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L. CalOptima Health shall obtain Authorization from the Member for the designation of an Authorized Representative for the Appeal and Grievance Process in instances where a member does not have a personal representative but is designating an individual or agency for such purposes. The authorization for the Appeal and Grievance Process refers to the submission of Appeals and Grievances, receipt of communication and correspondence, access to relevant protected health information (PHI), and participation in activities related to the review and resolution of Appeals and Grievances.

M. Authorization shall be obtained from the Member for any Use or Disclosure of PHI for Marketing, except when:

1. Face-to-face communication is made by CalOptima Health to the Member; or

2. The communication is in the form of a promotional gift of nominal value provided by CalOptima Health.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Appeals and Grievance Authorized Representative Designation Form
B. Authorization for CalOptima Health to Disclose Protected Health Information (PHI) to Another Person or Entity
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Compliance Plan
G. CalOptima Health Policy HH.3003: Verification of Identity for Disclosure of Protected Health Information
H. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information
I. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
J. California Civil Code, §§56.10(c), 56.11(b) and 56.104
K. Health Insurance Portability and Accountability Act (HIPAA) Authorization Checklist
L. Instruction Sheet for CalOptima Health, HIPAA Disclosure of Protected Health Information (PHI)
M. NCQA Standard MED5 Privacy and Confidentiality: Factor B – 2017
N. Revocation of Authorization for Release of PHI
O. Title 22, Code of California Regulations (C.C.R.), §51009
P. Title 42, Code of Federal Regulations (C.F.R.), Part 2
Q. Title 45, Code of Federal Regulations (C.F.R.), §§164.502(a)(iv), 164.506(a), and 164.508, 164.512
R. Welfare & Institutions Code, §14100.2

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

For 20261105 BOD Review Only

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/06/2025	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	04/01/2007	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2008	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2010	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2011	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2013	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	01/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	11/01/2014	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	09/01/2015	HH.3015	Authorization for Release of Protected Health Information (PHI)	Medi-Cal
Revised	12/01/2016	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Reviewed	05/01/2017	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised	10/01/2024	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised	11/01/2025	HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE
Revised		HH.3015	Member Authorization for the Use and Disclosure of Protected Health Information	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Authorization	Has the meaning given such term in 45 CFR § 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI, *e.g.*, Welfare & Institution Code § 14100.2.
De-Identified Information	Health information that does not identify a Member and does not provide a reasonable basis to believe that the information can be Used to identify a Member.
Disclosure	Has the meaning given such term in 45 CFR § 160.103 including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Grievance	Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A Complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.
Grievance and Appeals Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances and Appeals.
Health Care Operations	Has the meaning given such term in 45 CFR § 164.501 including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

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Term	Definition
Marketing	Medi-Cal: Any activity conducted by or on behalf of CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade or influence eligible beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima Health. OneCare: Activities and use of materials that are conducted by CalOptima Health with the intent to draw a beneficiary's attention to CalOptima Health and to influence a beneficiary's decision- making process when selecting a plan for enrollment or deciding to stay enrolled in a plan (that is, retention-based marketing). Additionally, marketing contains information about CalOptima Health's benefit structure, cost sharing, measuring or ranking standards. PACE: Any activity conducted by or on behalf of CalOptima Health PACE where information regarding the services offered by CalOptima Health PACE is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima Health PACE.
Member	A beneficiary enrolled in a CalOptima Health Program.
Payment	Activities carried out by CalOptima Health including: 1. Determination eligibility, risk adjustments based on the Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification or charges; and 3. Utilization review activities including pre-certification, pre-Authorization, concurrent, or retrospective review of services.
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
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 Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3020
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	07/01/2007
Revised Date:	
Applicable to:	☐ Administrative ~~☐~~☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes CalOptima Health's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/Personally Identifiable Information (PHI/PII) and/or other unauthorized access, Use, or Disclosure of PHI/PII to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima Health Employees shall immediately and no later than twenty-four (24) hours from time of discovery report any suspected or known Security Incidents, Breaches of Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with this Policy.

B. Business Associates shall notify CalOptima Health of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII immediately and no later than twenty-four (24) hours from time of discovery. Business Associates shall submit a written report to CalOptima Health of suspected, or known, Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use or Disclosure of PHI/PII, in accordance with this Policy.

C. CalOptima Health shall investigate such a Security Incident, Breach of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII and provide a written report of the investigation to the Department of Health Care Services (DHCS) in accordance with this Policy.

D. CalOptima Health shall report Security Incidents, Breaches of Unsecured PHI/PII, or other unauthorized access, Use or Disclosure of PHI/PII to regulators, as required by its regulatory contracts and applicable state and federal laws.

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E. CalOptima Health shall notify individual Members whose Unsecured PHI/PII has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima Health, which compromises the security or privacy of the PHI/PII.

F. CalOptima Health shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PII in accordance with CalOptima Health policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima Health management, at its discretion, shall issue corrective action to Employees and persons in CalOptima Health's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII in accordance with the HIPAA Violation Guidelines Matrix. CalOptima Health shall document any corrective actions that are applied.

H. Business Associates shall comply with CalOptima Health Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/PII or other unauthorized access, Use, or Disclosure of PHI/PII involves DHCS and/or CalOptima Health PHI/PII.

III. PROCEDURE

A. Discovery

1. CalOptima Health Employees, Health Networks, with the exception of a Health Maintenance Organization (HMO) that satisfies the requirements of Section III.B.2. of this Policy, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII immediately and no later than twenty-four (24) hours from time of discovery to the CalOptima Health Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI or PII;

      ii. Posting PHI or PII on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted, including emails that contain PHI/PII in the email subject line;

      v. Cybersecurity or hacking;

      vi. Downloading EPHI to a portable device in violation of CalOptima Health's policies (e.g., without expressed authority and required safeguards (encryption));

      vii. Faxes or emails that contain CalOptima Health PHI are misdirected to an unintended third party due to incorrect fax numbers or emails; and

      viii. Theft of paper records with CalOptima Health PHI from an Employee's vehicle.

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B. The CalOptima Health Privacy Officer or Designee shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. CalOptima Health shall notify DHCS immediately and no later than twenty-four (24) hours from the time of discovery of a suspected Breach, Security Incident, or unauthorized access, Use, or disclosure that involves SSA data. This notification will be provided through the DHCS Privacy Incident Reporting Portal . If CalOptima Health is unable to provide notification via the DHCS Privacy Incident Reporting Portal, then CalOptima Health shall provide notice by email or telephone to DHCS.

b. CalOptima Health shall notify DHCS within twenty-four (24) hours via the DHCS Privacy Incident Reporting Portal (by email or telephone if necessary) of the discovery of:

i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

ii. Any suspected Security Incident which risks unauthorized access to PHI and/or other confidential information;

iii. Any Intrusion or unauthorized access, Use or disclosure of PHI in violation of CalOptima Health's Business Associate Agreement with DHCS; or

iv. Potential loss of confidential data affecting CalOptima Health's Business Associate Agreement with DHCS;

c. Notice shall be made via the DHCS Privacy Incident Reporting Portal and shall include all information known at the time the incident is reported.

d. The CalOptima Health Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer via the DHCS Privacy Incident Reporting Portal (by email or telephone, if necessary), as required and within twenty-four (24) hours.

2. Investigation and written report to DHCS:

a. Within ten (10) working days of the initial discovery, the CalOptima Health Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer by using the DHCS Privacy Incident Reporting Portal .

C. CalOptima Health shall notify Members whose Unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises

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the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days from the date of discovery, which is the first day the Breach is known by a Covered Entity or would have been known by exercising reasonable diligence. CalOptima Health shall provide notification as specified below.

1. CalOptima Health shall write the notification in plain language and include, to the extent possible:

    a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

    b. A description of the types of Unsecured PHI/PII that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

    c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

    d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

    e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima Health shall provide notification in the following form:

    a. CalOptima Health shall send written notification by first-class mail to the Member at the last known address. CalOptima Health may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail and such agreement has not been withdrawn. CalOptima Health may provide notification in one (1) or more mailings as information is available.

        i. If the Member is deceased, CalOptima Health shall provide written notification by first- class mail to either the next of kin, or personal representative of the Member, if contact information is known.

        ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima Health may provide a substitute notice by an alternative form of written notice, telephone, or other means.

        iii. If current contact information is unavailable for ten (10) or more Members, CalOptima Health shall provide a substitute notice by a readily visible posting on the homepage of CalOptima Health's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media in the geographic areas where the Members affected by the Breach likely reside. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

    b. If CalOptima Health deems a Breach incident to require urgency because of a possible

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imminent misuse of Unsecured PHI/PII, CalOptima Health may provide Breach notification to Members by telephone or other means, in addition to written notice.

3. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

D. The CalOptima Health Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /PII as follows:

1. For Breaches of Unsecured PHI/PII involving five hundred (500) or more Members, the CalOptima Health Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/PII involving less than five hundred (500) Members, the CalOptima Health Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

E. For CMS reporting, CalOptima Health is required to follow the directions provided by HHS' Office for Civil Rights (OCR) related to the Health Information and Technology for Economic and Clinical Health (HITECH) breach notification regulations. Additional information, including a description of breach notification requirements, instructions for covered entities to submit breach notifications to the Secretary, and links to the online breach notification forms, can be found at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule

F. The CalOptima Health Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was Used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). A "CMS Security and Privacy Incident Report" should be submitted for high-risk CalOptima Health breaches by email to CMS_IT_Service_desk@cms.hhs.gov. CalOptima Health shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories. The CalOptima Health Privacy department (Privacy) will include the Regulatory Affairs & Compliance (RAC) Medicare department (RAC Medicare) in this correspondence. In cases where CalOptima Health has notified OCR of the breach within this timeframe, CalOptima Health can send a copy of the breach report to the CMS Account Manager.

G. For National Committee for Quality Assurance (NCQA) Reportable Event Assessment and Reporting Requirements, the Privacy Officer shall assess each incident to determine whether it meets NCQA Reportable Event criteria. The assessment shall consider the nature, scope, severity, and organizational impact of the incident, including whether the event may materially affect CalOptima Health's ability to meet NCQA accreditation standards, the effectiveness of privacy, security, or compliance programs, member privacy protections, regulatory compliance obligations, or public confidence in CalOptima Health's operations.

1. The Privacy Officer shall determine whether the incident involves:

a. A significant unauthorized use or disclosure of PHI;

b. A large-scale privacy or cybersecurity incident;

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c. A systemic control or process failure affecting the protection of PHI;

d. A significant incident involving a Business Associate or delegated entity that materially affects CalOptima Health or its members;

e. A governmental investigation, enforcement action, fine, sanction, license suspension, or settlement related to privacy or security compliance; or

f. Any other event that could reasonably affect CalOptima Health's NCQA accreditation status.

2. When an incident constitutes an NCQA Reportable Event, the Privacy Officer shall immediately notify the Quality Improvement (QI) Department. The QI Department is responsible for submitting NCQA Reportable Events to NCQA through MyNCQA in accordance with required timeframes. Notification shall also be provided to the Compliance Officer, RAC, and other relevant operational leadership.

3. Incidents that meet NCQA's materiality thresholds must be reported to NCQA within thirty (30) calendar days. NCQA- reportable events include, but are not limited to:

a. Regulatory sanctions, major fines, or licensure suspensions;

b. Cyberattacks affecting five (5) percent or more of Utilization Management, Case Management or Clinical Review files;

c. System operational failures affecting five (5) percent or more of NCQA-reviewed functions.

4. HIPAA incidents are considered NCQA-reportable incidents only when they meet NCA's materiality thresholds. A HIPAA breach may become an NCQA Reportable Incident if it results in a regulatory sanction, indicates a significant system failure, or involves large-scale member impact.

5. If an incident involves another covered entity, the Privacy Officer shall assess whether the event materially impacts CalOptima Health, its members, delegated functions, contractual obligations, or accreditation status. The existence of another covered entity's reporting requirements does not eliminate CalOptima Health's independent NCQA reporting obligations.

6. The Privacy Officer shall ensure all NCQA reportability determinations are documented, including assessment rational, materiality factors, timelines, notifications, and coordination with QI. Documentation shall be retained in accordance with record-retention requirements.

~~G.~~H. On a monthly basis, Privacy shall provide reported breaches to RAC Medicare via the CalOptima Health Compliance Log. If there were no breaches during a given month, a notification email shall be sent to RAC Medicare confirming that no breaches have occurred. RAC Medicare should provide updated reports to the CMS Account Manager as necessary.

~~H.~~I. The CalOptima Health Privacy Officer, or Designee shall notify the PACE Account Managers,

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and copy RAC Medicare, regarding security and privacy breaches involving PACE Participants. Breaches must be reported as soon as practical via email, using the "PACE Privacy Breach Notification Timeline and Summary" form.

~~I.~~J. For a Breach of Unsecured PHI/PII affecting more than five hundred (500) individuals, CalOptima Health shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

~~J.~~K. If a law enforcement official states to CalOptima Health that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima Health shall take the following action:

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima Health staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima Health staff shall:

   a. Document the statement, including the identity of the official making the statement; and

   b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.I. of this Policy is submitted during that time.

IV. ATTACHMENT(S)

Not Applicable
~~A. HIPAA Violation Guidelines Matrix~~
~~B.~~A. ~~CMS Security and Privacy Incident Report Form~~
~~C.~~A. ~~PACE Privacy Breach Notification Timeline and Summary Form~~

V. REFERENCE(S)

A. 2026 NCQA Health Accreditation Standards and Guidelines
~~A.~~B. CalOptima Health Business Associates Agreement
~~B.~~C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CMS Security and Privacy Incident Report Form
~~C.~~E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D.~~F. CalOptima Health PACE Program Agreement
~~E.~~G. CalOptima Health Privacy Program
~~F.~~H. CalOptima Health Compliance Plan
~~G.~~I. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
~~H.~~J. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
~~I.~~K. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-005: Protected Health Information (PHI) and Notification of Breaches
~~J.~~L. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
M. HIPAA Violation Guidelines Matrix

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N. PACE Privacy Breach Notification Timeline and Summary Form
~~K.~~O. "Security and Privacy Reminders and Clarification of Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 12/16/2008
~~L.~~P. Title 45, Code of Federal Regulations §164.400 - 414 et seq.
~~M.~~Q. Title 45, Code of Federal Regulations §164.502
~~N.~~R. Title 45, Code of Federal Regulations §164.514
~~O.~~S. Title 45, Code of Federal Regulations §164.530(e)(1)
~~P.~~T. Title 42 United State Code (U.S.C) §17932(h)
~~Q.~~U. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/22/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal

Rev. Only

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PII	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2025	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PII	Medi-Cal OneCare PACE
Revised		HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PII	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a Covered Entity or Business Associate to another person authorized to access protected health information at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Corrective Action Plan (CAP)	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), 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 Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
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.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
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	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.

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Term	Definition
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Member	A beneficiary enrolled in a CalOptima Health program.
MyNCQA	NCQA's secure reporting portal used to submit required notificatios regarding material events.
National Committee for Quality Assurance (NCQA)	A national accrediting body that establishes quality standards for health plans and requires reporting of certain material events that may affect the organization's accreditation status or reviewed functions.
NCQA Materiality Definition	An actual or potential effect on the Organization's operations, regulatory compliance, accreditation status, privacy or security program, delegated functions, member protections, or public trust that warrants executive review and evaluation for external reporting obligations.
NCQA Reportable Event	An incident that meets NCQAs materiality criteria requiring reporting within 30 calendar days, including regulatory sanctions, major fines, licensure actions, cyberattacks affecting 5% or more of NCQA-reviewed files (e.g., UM, CM, CR) or results in widespread member or organizational impact.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.

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Term	Definition
Unsecured Protected Health Information/Personal Information (PHI/PII)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

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Policy:	HH.3020
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	07/01/2007
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy describes CalOptima Health's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/Personally Identifiable Information (PHI/PII) and/or other unauthorized access, Use, or Disclosure of PHI/PII to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima Health Employees shall immediately and no later than twenty-four (24) hours from time of discovery report any suspected or known Security Incidents, Breaches of Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with this Policy.

B. Business Associates shall notify CalOptima Health of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII immediately and no later than twenty-four (24) hours from time of discovery. Business Associates shall submit a written report to CalOptima Health of suspected, or known, Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use or Disclosure of PHI/PII, in accordance with this Policy.

C. CalOptima Health shall investigate such a Security Incident, Breach of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII and provide a written report of the investigation to the Department of Health Care Services (DHCS) in accordance with this Policy.

D. CalOptima Health shall report Security Incidents, Breaches of Unsecured PHI/PII, or other unauthorized access, Use or Disclosure of PHI/PII to regulators, as required by its regulatory contracts and applicable state and federal laws.

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E. CalOptima Health shall notify individual Members whose Unsecured PHI/PII has been or believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima Health, which compromises the security or privacy of the PHI/PII.

F. CalOptima Health shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PII in accordance with CalOptima Health policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima Health management, at its discretion, shall issue corrective action to Employees and persons in CalOptima Health's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII in accordance with the HIPAA Violation Guidelines Matrix. CalOptima Health shall document any corrective actions that are applied.

H. Business Associates shall comply with CalOptima Health Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/PII or other unauthorized access, Use, or Disclosure of PHI/PII involves DHCS and/or CalOptima Health PHI/PII.

III. PROCEDURE

A. Discovery

1. CalOptima Health Employees, Health Networks, with the exception of a Health Maintenance Organization (HMO) that satisfies the requirements of Section III.B.2. of this Policy, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII immediately and no later than twenty-four (24) hours from time of discovery to the CalOptima Health Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI or PII;

      ii. Posting PHI or PII on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted, including emails that contain PHI/PII in the email subject line;

      v. Cybersecurity or hacking;

      vi. Downloading EPHI to a portable device in violation of CalOptima Health's policies (e.g., without expressed authority and required safeguards (encryption));

      vii. Faxes or emails that contain CalOptima Health PHI are misdirected to an unintended third party due to incorrect fax numbers or emails; and

      viii. Theft of paper records with CalOptima Health PHI from an Employee's vehicle.

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B. The CalOptima Health Privacy Officer or Designee shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

a. CalOptima Health shall notify DHCS immediately and no later than twenty-four (24) hours from the time of discovery of a suspected Breach, Security Incident, or unauthorized access, Use, or disclosure that involves SSA data. This notification will be provided through the DHCS Privacy Incident Reporting Portal . If CalOptima Health is unable to provide notification via the DHCS Privacy Incident Reporting Portal, then CalOptima Health shall provide notice by email or telephone to DHCS.

b. CalOptima Health shall notify DHCS within twenty-four (24) hours via the DHCS Privacy Incident Reporting Portal (by email or telephone if necessary) of the discovery of:

i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

ii. Any suspected Security Incident which risks unauthorized access to PHI and/or other confidential information;

iii. Any Intrusion or unauthorized access, Use or disclosure of PHI in violation of CalOptima Health's Business Associate Agreement with DHCS; or

iv. Potential loss of confidential data affecting CalOptima Health's Business Associate Agreement with DHCS;

c. Notice shall be made via the DHCS Privacy Incident Reporting Portal and shall include all information known at the time the incident is reported.

d. The CalOptima Health Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer via the DHCS Privacy Incident Reporting Portal (by email or telephone, if necessary), as required and within twenty-four (24) hours.

2. Investigation and written report to DHCS:

a. Within ten (10) working days of the initial discovery, the CalOptima Health Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer by using the DHCS Privacy Incident Reporting Portal .

C. CalOptima Health shall notify Members whose Unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises

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the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days from the date of discovery, which is the first day the Breach is known by a Covered Entity or would have been known by exercising reasonable diligence. CalOptima Health shall provide notification as specified below.

1. CalOptima Health shall write the notification in plain language and include, to the extent possible:

    a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

    b. A description of the types of Unsecured PHI/PII that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

    c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

    d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

    e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima Health shall provide notification in the following form:

    a. CalOptima Health shall send written notification by first-class mail to the Member at the last known address. CalOptima Health may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail and such agreement has not been withdrawn. CalOptima Health may provide notification in one (1) or more mailings as information is available.

        i. If the Member is deceased, CalOptima Health shall provide written notification by first- class mail to either the next of kin, or personal representative of the Member, if contact information is known.

        ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima Health may provide a substitute notice by an alternative form of written notice, telephone, or other means.

        iii. If current contact information is unavailable for ten (10) or more Members, CalOptima Health shall provide a substitute notice by a readily visible posting on the homepage of CalOptima Health's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media in the geographic areas where the Members affected by the Breach likely reside. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

    b. If CalOptima Health deems a Breach incident to require urgency because of a possible

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imminent misuse of Unsecured PHI/PII, CalOptima Health may provide Breach notification to Members by telephone or other means, in addition to written notice.

3. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

D. The CalOptima Health Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /PII as follows:

1. For Breaches of Unsecured PHI/PII involving five hundred (500) or more Members, the CalOptima Health Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/PII involving less than five hundred (500) Members, the CalOptima Health Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

E. For CMS reporting, CalOptima Health is required to follow the directions provided by HHS' Office for Civil Rights (OCR) related to the Health Information and Technology for Economic and Clinical Health (HITECH) breach notification regulations. Additional information, including a description of breach notification requirements, instructions for covered entities to submit breach notifications to the Secretary, and links to the online breach notification forms, can be found at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule

F. The CalOptima Health Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was Used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). A "CMS Security and Privacy Incident Report" should be submitted for high-risk CalOptima Health breaches by email to CMS_IT_Service_desk@cms.hhs.gov. CalOptima Health shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories. The CalOptima Health Privacy department (Privacy) will include the Regulatory Affairs & Compliance (RAC) Medicare department (RAC Medicare) in this correspondence. In cases where CalOptima Health has notified OCR of the breach within this timeframe, CalOptima Health can send a copy of the breach report to the CMS Account Manager.

G. For National Committee for Quality Assurance (NCQA) Reportable Event Assessment and Reporting Requirements, the Privacy Officer shall assess each incident to determine whether it meets NCQA Reportable Event criteria. The assessment shall consider the nature, scope, severity, and organizational impact of the incident, including whether the event may materially affect CalOptima Health's ability to meet NCQA accreditation standards, the effectiveness of privacy, security, or compliance programs, member privacy protections, regulatory compliance obligations, or public confidence in CalOptima Health's operations.

1. The Privacy Officer shall determine whether the incident involves:

a. A significant unauthorized use or disclosure of PHI;

b. A large-scale privacy or cybersecurity incident;

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c. A systemic control or process failure affecting the protection of PHI;

d. A significant incident involving a Business Associate or delegated entity that materially affects CalOptima Health or its members;

e. A governmental investigation, enforcement action, fine, sanction, license suspension, or settlement related to privacy or security compliance; or

f. Any other event that could reasonably affect CalOptima Health's NCQA accreditation status.

2. When an incident constitutes an NCQA Reportable Event, the Privacy Officer shall immediately notify the Quality Improvement (QI) Department. The QI Department is responsible for submitting NCQA Reportable Events to NCQA through MyNCQA in accordance with required timeframes. Notification shall also be provided to the Compliance Officer, RAC, and other relevant operational leadership.

3. Incidents that meet NCQA's materiality thresholds must be reported to NCQA within thirty (30) calendar days. NCQA- reportable events include, but are not limited to:

a. Regulatory sanctions, major fines, or licensure suspensions;

b. Cyberattacks affecting five (5) percent or more of Utilization Management, Case Management or Clinical Review files;

c. System operational failures affecting five (5) percent or more of NCQA-reviewed functions.

4. HIPAA incidents are considered NCQA-reportable incidents only when they meet NCA's materiality thresholds. A HIPAA breach may become an NCQA Reportable Incident if it results in a regulatory sanction, indicates a significant system failure, or involves large-scale member impact.

5. If an incident involves another covered entity, the Privacy Officer shall assess whether the event materially impacts CalOptima Health, its members, delegated functions, contractual obligations, or accreditation status. The existence of another covered entity's reporting requirements does not eliminate CalOptima Health's independent NCQA reporting obligations.

6. The Privacy Officer shall ensure all NCQA reportability determinations are documented, including assessment rational, materiality factors, timelines, notifications, and coordination with QI. Documentation shall be retained in accordance with record-retention requirements.

H. On a monthly basis, Privacy shall provide reported breaches to RAC Medicare via the CalOptima Health Compliance Log. If there were no breaches during a given month, a notification email shall be sent to RAC Medicare confirming that no breaches have occurred. RAC Medicare should provide updated reports to the CMS Account Manager as necessary.

I. The CalOptima Health Privacy Officer, or Designee shall notify the PACE Account Managers,

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and copy RAC Medicare, regarding security and privacy breaches involving PACE Participants. Breaches must be reported as soon as practical via email, using the "PACE Privacy Breach Notification Timeline and Summary" form.

J. For a Breach of Unsecured PHI/PII affecting more than five hundred (500) individuals, CalOptima Health shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

K. If a law enforcement official states to CalOptima Health that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima Health shall take the following action:

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima Health staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima Health staff shall:

   a. Document the statement, including the identity of the official making the statement; and

   b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.I. of this Policy is submitted during that time.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. 2026 NCQA Health Accreditation Standards and Guidelines
B. CalOptima Health Business Associates Agreement
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CMS Security and Privacy Incident Report Form
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Privacy Program
H. CalOptima Health Compliance Plan
I. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-005: Protected Health Information (PHI) and Notification of Breaches
L. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
M. HIPAA Violation Guidelines Matrix
N. PACE Privacy Breach Notification Timeline and Summary Form
O. "Security and Privacy Reminders and Clarification of Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 12/16/2008
P. Title 45, Code of Federal Regulations §164.400 - 414 et seq.

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Q. Title 45, Code of Federal Regulations §164.502
R. Title 45, Code of Federal Regulations §164.514
S. Title 45, Code of Federal Regulations §164.530(e)(1)
T. Title 42 United State Code (U.S.C) §17932(h)
U. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/22/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal

For Review

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PII	Medi-Cal OneCare PACE
Revised	11/01/2025	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PII	Medi-Cal OneCare PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised		HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PII	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a Covered Entity or Business Associate to another person authorized to access protected health information at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Corrective Action Plan (CAP)	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), 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 Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
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.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
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	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.

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Term	Definition
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Member	A beneficiary enrolled in a CalOptima Health program.
MyNCQA	NCQA's secure reporting portal used to submit required notificatios regarding material events.
National Committee for Quality Assurance (NCQA)	A national accrediting body that establishes quality standards for health plans and requires reporting of certain material events that may affect the organization's accreditation status or reviewed functions.
NCQA Materiality Definition	An actual or potential effect on the Organization's operations, regulatory compliance, accreditation status, privacy or security program, delegated functions, member protections, or public trust that warrants executive review and evaluation for external reporting obligations.
NCQA Reportable Event	An incident that meets NCQAs materially criteria requiring reporting within 30 calendar days, including regulatory sanctions, major fines, licensure actions, cyberattacks affecting 5% or more of NCQA-reviewed files (e.g., UM, CM, CR) or results in widespread member or organizational impact.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.

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Term	Definition
Unsecured Protected Health Information/Personal Information (PHI/PII)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

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Policy:	HH.3023
Title:	**Information Sharing**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	10/05/2023
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes CalOptima Health's governance for the collection, use, disclosure, exchange, and electronic availability of Protected Health Information (PHI), Personally Identifiable Information (PII), and United States Core Data for Interoperability (USCDI) through health information exchanges (HIEs), Application Programming Interfaces (APIs), the California Data Exchange Framework (DxF), and other interoperable technologies. This policy also establishes requirements for compliance with federal interoperability requirements, including Patient Access APIs, Provider Access APIs, Payer-to-Payer APIs, Prior Authorization APIs, and information exchange requirements established by the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). This policy outlines CalOptima Health's process for sharing information with participating First Tier, Downstream, and Related Entities (FDRs), local health jurisdictions, county and public agencies, and other MCPs to coordinate Medicare and Medi-Cal Covered Services. It also governs the disclosure of PHI necessary for calculating, validating, auditing, and paying the DHCS Directed Payment Initiative and alternate payment methodology programs.

II. POLICY

A. CalOptima Health shall participate in data sharing exchanges, such as health information exchanges and community information exchanges, that permit the sharing of Personally Identifiable Information (PII) and/or Protected Health Information (PHI), as defined by the California Health and Human Services Data Exchange Framework (DxF) and in accordance with Health & Safety (H&S) Code section 130290. CalOptima Health shall comply with federal and state privacy laws and each data sharing agreement, as applicable.

CalOptima Health shall implement and maintain standards-based interoperability capabilities using HL7® FHIR® APIs, consistent with CMS interoperability regulations, DHCS guidance, and applicable ONC certification requirements. APIs shall support secure electronic exchange of health information between Members, Providers, other payers, and authorized third-party applications.

1. CalOptima Health may disclose PHI to Providers, DHCS, and DHCS designated contractors without Member authorization when such disclosure is necessary for payment, healthcare operations, quality measurement, rate calculation and validation of Directed Payment Initiative and alternate payment methodology programs, as required by DHCS.

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B. CalOptima Health timely executed the DxF Data Sharing Agreement (DSA) before January 31, 2023. By January 31, 2024, exchanged health and social services information or provide access to health information as specified in the DSA and its policies and procedures.

C. CalOptima Health shall integrate disparate information to support the California Advancing and Innovating Medi-Cal (CalAIM) and Population Health Management (PHM) programs by performing key PHM functions and providing authorized users with access to timely, accurate, and comprehensive data on Member's health history and needs.

D. CalOptima Health interoperability shall enhance PHM services, in support of population health principals, integrated care and care coordination across delivery systems.

E. CalOptima Health shall integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members.

F. CalOptima Health shall ~~share the~~exchange United States Core Data for Interoperability (USCDI) ~~as specified in Title 45 Code of Federal Regulations (CFR) 170.213, as necessary, to allow for data exchange with Health~~using federally adopted interoperability standards, including HL7® FHIR®, and shall implement updated USCDI versions as required by CMS, ONC, or DHCS. Information ~~Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by the Department of Health Care Services (DHCS).~~ exchanged shall include all data elements required under applicable interoperability regulations, including claims, encounters, clinical data, laboratory results, prior authorization information, and provider directory information, where applicable.

G. CalOptima Health shall exchange necessary data to implement Continuity of Care (CoC) protections. CalOptima Health shall complete all data sharing requirements as a previous MCP or a receiving MCP, as applicable, as specified in the 2024 DHCS Medi-Cal Managed Care Plan Transition Policy Guide, Section VIII. Continuity of Care Data Sharing Policy. CalOptima Health shall implement and maintain: Patient Access API, Provider Access API, Payer-to-Payer API, Prior Authorization API. APIs shall utilize nationally recognized interoperability standards including HL7® FHIR®, SMART on FHIR, OAuth 2.0 authentication, and any implementation guides adopted by CMS or DHCS. CalOptima Health shall monitor API availability, security, performance, audit logging, and compliance with applicable interoperability requirements.

H. CalOptima Health shall provide the DHCS with administrative, clinical, and other data requirements as specified by DHCS when requested.

I. CalOptima Health shall not disclose PII/PHI unless permitted or required by applicable law Disclosure of PII/PHI for treatment, payment, and/or health care operations, quality measurement, and Directed Payment Initiative or alternate payment methodology programs shall not require Member authorization where permitted by HIPAA and mandated by DHCS. CalOptima Health may disclose PHI through CMS-required interoperability APIs without Member Authorization when such disclosure is expressly permitted or required under HIPAA, CMS interoperability regulations, applicable Medicaid regulations, or DHCS guidance. Member-directed disclosures through the Patient Access API shall be made in accordance with federal interoperability requirements.

J. CalOptima Health shall adhere to stricter patient confidentiality laws when it applies and, when applicable, the federal substance use disorder confidentiality regulation, 42 CFR Part 2. CalOptima Health shall disclose behavioral health and substance use disorder PHI, including 42 CFR Part 2 data, when legally permissible for payment, healthcare operations, quality measurement, and Directed Payment Initiative validation. Disclosures under this section shall be limited to the minimum necessary PHI required to calculate, validate, audit, or reconcile the applicable quality

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measure or payment. Electronic exchange of Part 2 records shall utilize appropriate data segmentation and access controls to ensure compliance with applicable federal confidentiality requirements while supporting interoperable exchange where legally permitted.

K. When information may be shared under HIPAA and other applicable laws, CalOptima Health may share only the minimum information necessary to accomplish the purpose of the disclosure, pursuant to CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

1. For Directed Payment Initiative and quality measure disclosures, the HIPAA minimum necessary standard shall be defined by the DHCS-specified numerator, denominator, and measure specifications. CalOptima Health shall not limit disclosures based on primary care assignment, attribution, or internal segmentation where the DHCS-defined denominator includes additional Members. The HIPAA Minimum Necessary Standard shall not apply to disclosures made directly to the Member through the CMS-required Patient Access API or other disclosures where the Minimum Necessary Standard does not apply under HIPAA. Minimum Necessary requirements shall continue to apply to treatment, payment, health care operations, quality measurement, and other disclosures unless otherwise permitted by law.

L. Where a Business Associate Agreement (BAA) applies, CalOptima Health's BAA template must be effectuated before sharing PII and/or PHI with an external party, pursuant to CalOptima Health Policy HH.3022: Business Associate Agreements.

M. A Member may request to restrict or limit information sharing in accordance with applicable statutory, regulatory, and contractual requirements, as permissible under CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information.

N. Members shall have the ability to electronically access required health information through standards-based APIs consistent with CMS interoperability regulations. Members may authorize third-party applications to retrieve their information. CalOptima Health shall provide Members with educational information regarding the privacy and security risks associated with third-party applications that are not covered entities or business associates under HIPAA.

O. CalOptima Health shall not engage in practices that are likely to interfere with, prevent, materially discourage, or otherwise inhibit lawful access, exchange, or use of electronic health information except where an exception under applicable federal law applies. Decisions to deny or delay electronic information exchange shall be documented and supported by an applicable legal or regulatory exception.

III. PROCEDURE

A. As a Previous MCP, CalOptima Health shall transmit utilization data, authorization data, Member information, including preferred form of communication, accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to receiving MCPs, in accordance with the CoC Data Sharing Policy.

B. Where technically feasible, ECM information shall be exchanged through standards-based electronic interfaces consistent with CMS interoperability requirements and the California Data Exchange Framework. CalOptima Health shall provide the following information to Enhanced Care Management (ECM) Providers:

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1. Member assignment files, which include listing of Members authorized and assigned to the ECM Provider;

2. Historical encounters/claims data for assigned Members;

3. Physical, behavioral and administrative information, and information indicating Member Social Drivers of Health (SDOH) needs;

4. Reports of performance on quality measures, as requested.

C. Admission, Discharge, and Transfer (ADT) information

1. CalOptima Health shall require contracted Hospitals and Skilled Nursing Facilities (SNFs) to provide timely notifications of Member admissions, discharges, and/or transfers (ADT). Hospital and SNF information shall be exchanged in shared information systems.

2. CalOptima Health shall maintain contracts with vendors to supply ADT messages in support of this policy.

   a. Hospitals shall notify CalOptima Health of ADT information either immediately, prior to, or at the time of the Member's discharge or transfer from the Hospital's inpatient services.

   b. For SNF admissions, the SNF shall notify CalOptima Health within 48 hours of admission.

   c. For SNF discharges or transfers, the SNF shall notify CalOptima Health in advance if at all possible, or at the time of the discharge or transfer.

3. CalOptima Health shall ensure that data exchanged is appropriately linked to the correct, real person.

4. ADT information shall be made available through interoperable systems supporting continuity of Care, care coordination, and Provider Access API requirements where applicable.

D. For mandatory data disclosures, CalOptima Health shall provide Providers and DHCS designated contractors with the following PHI and administrative data when required to support quality measure and Directed Payment Initiative programs:

1. ADT feeds via DxF Qualified Health Information Organizations in real time;

2. Enrollment files and rosters within seven (7) calendar days of request;

3. Pharmacy claims, including behavioral health medications, within fourteen (14) calendar days;

4. Professional, facility, and behavioral health claims, including Part 2 data where legally permissible, within thirty (30) calendar days; and

5. Quality measure rates, numerators, denominators, and underlying data within forty-five (45) calendar days.

6. Any other PHI or administrative data required by DHCS/APL 25-015: Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs-. Prior Authorization status information, including requests, determinations,

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supporting documentation, and decision rationale, shall be made available through the Prior Authorization API consistent with CMS interoperability requirements.

E. CalOptima Health shall maintain a formal dispute resolution process for Provider to challenge data, quality measure calculations, and performance rates. When a Provider requests Member-level PHI to validate or dispute a measure, CalOptima Health shall disclose the PHI necessary to reproduce the calculation.

F. CalOptima Health shall ensure that all subcontractors, vendors, and downstream entities comply with the PHI disclosure and quality data requirement of applicable DHCS All Plan Letters (APLs), including but not limited to, APL 25-015: Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs. The Delegation of data functions does not relieve CalOptima Health of responsibility.

G. In accordance with all NCQA PHM standards, CalOptima Health shall exchange the following data to ensure the ability to assess the needs of all Members:

1. Medical and behavioral claims or encounters;
2. Pharmacy claims;
3. Laboratory results;
4. Health appraisal status;
5. Electronic health records; and
6. Health services programs within the organization

H. In accordance with California Penal Code Section 4011.11, disclosure of PII is permitted if the disclosure is:

1. Reasonably necessary to facilitate a county jail or youth correctional inmate's enrollment in CalOptima Health;
2. Reasonably necessary to facilitate a county jail or youth correctional inmate's behavioral health treatment post-release; and
3. Complies with federal laws.

I. External data sharing requests shall undergo CalOptima Health's data sharing review procedure.

J. Prior Authorization status information, including requests, determinations, supporting documentation, and decision rationale, shall be made available through the Prior Authorization API consistent with CMS interoperability requirements.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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1. 2024 Department of Healthcare Services (DHCS) Medi-Cal Managed Care Plan Transition Policy Guide, March 22, 2024
2. 21st Century Cures Act, Information Blocking Rule, 45 CFR Part 171.
~~2.~~3. CalAIM Enhanced Care Management Policy Guide, August 2024
~~3.~~4. CalAIM Data Sharing Authorization Guidance, October 2025
~~4.~~5. CalAIM D-SNP Policy Guide, September 2025
~~5.~~6. CalAIM Population Health Management Policy Guide, July 2025
~~6.~~7. California Health and Human Services Data Exchange Framework: Single Data Sharing Agreement
8. California Health & Safety Code §130290 (Data Exchange Framework).
~~7.~~9. California Penal Code Section 4011.11
~~8.~~10. CalOptima Health Contract with Department of Health Care Services (DHCS)
~~9.~~11. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
~~10.~~12. CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information
~~11.~~13. CalOptima Health Policy HH.3022: Business Associate Agreements
14. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).
~~12.~~15. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
~~13.~~16. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide
~~14.~~17. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-015: Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs
18. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-008: Interoperability Final Rules, Including Prior Authorization Requirements (Supersedes APL 22-026)
~~15.~~19. Title 45, Code of Federal Regulations (CFR~~)~~), Parts 160, 164 and 170, §§170.213 & 170.315

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/05/2023	HH.3023	Information Sharing	Medi-Cal OneCare
Revised	10/01/2024	HH.3023	Information Sharing	Medi-Cal OneCare
Revised	11/01/2025	HH.3023	Information Sharing	Medi-Cal OneCare
Revised	02/01/2026	HH.3023	Information Sharing	Medi-Cal OneCare

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Action	Date	Policy	Policy Title	Program(s)
Revised		HH.3023	Information Sharing	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Application Programming Interface (API)	A standardized set of technical specifications and protocols that allows separate software applications to securely communicate, exchange, and retrieve electronic health information without requiring direct access to another system's underlying database. For purposes of this policy, APIs include CMS-required Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs.
California Data Exchange Framework (DxF)	California's statewide data-sharing framework established under Health and Safety Code section 130290 to promote secure, standardized exchange of health and social services information among participating entities.
Continuity of Care	Covered California: Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship. Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing, and home health care.
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: 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,

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Term	Definition
	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; 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;

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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 DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Directed Payment Initiative	A payment arrangement that directs certain expenditures made by CalOptima Health under its contract with DHCS for Medi-Cal Services and that is either approved by CMS as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Electronic Health Information (EHI)	Electronic protected health information that is included within the data classes and elements adopted by the Office of the National Coordinator for Health Information Technology and is maintained in electronic form by or for CalOptima Health. The scope of EHI shall be interpreted consistent with applicable ONC regulations.
Enhanced Care Management (ECM) Provider	A Provider within the community that have a contractual relationship with CalOptima Health (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus.

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Term	Definition
Fast Healthcare Interoperability Resources (FHIR)	The Health Level Seven International (HL7®) interoperability standard adopted by the Office of the National Coordinator for Health Information Technology (ONC) for the secure electronic exchange of health information through standardized APIs. FHIR establishes common data formats and technical specifications that enable health information to be exchanged between health plans, providers, Members, and authorized third-party applications.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Health Information Exchange (HIE)	An organization or technology platform that enables the secure electronic exchange of health information among participating health care organizations, health plans, public health agencies, and other authorized entities in accordance with applicable federal and state law.
Interoperability	The capability of different information systems, devices, applications, or organizations to securely access, exchange, integrate, and use electronic health information in a coordinated manner that supports clinical care, care coordination, payment, public health, and health care operations. Interoperability includes the use of nationally recognized technical standards adopted by CMS, ONC, DHCS, or other applicable regulatory authorities.
Member	An individual enrolled in a CalOptima Health program.
OAuth 2.0	The industry-standard authorization framework used to authenticate and authorize secure access to interoperability APIs without requiring Members or Providers to disclose system passwords to third-party applications. OAuth supports secure delegated access to electronic health information.
Patient Access API	The federally required standards-based API that enables Members to securely access their health information electronically using applications of their choice, consistent with applicable federal and state law. Information available through the Patient Access API includes, as applicable: • Claims • Encounters • Clinical information • Laboratory results • Provider directory information • Prior authorization information • Other data required under CMS interoperability regulations.

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Term	Definition
Provider Access API	The CMS-required standards-based API that enables participating contracted Providers with a treatment relationship to electronically access Member health information necessary for treatment and care coordination, subject to applicable privacy and security requirements. Information exchanged shall be limited to data required under applicable CMS regulations and DHCS guidance.
Payer-to-Payer API	The CMS-required standards-based API that enables electronic exchange of a Member's health information between impacted payers, upon the Member's request, to facilitate continuity of care and reduce administrative burden when Members change health plans.
Personally Identifiable Information (PII)	~~PII is any~~Any information about an individual maintained by an agency, including: 1. Any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and 2. Any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information
Previous Managed Care Plan (MCP)	Previous MCP is the plan a member was enrolled in prior to transitioning to a new MCP.
Prior Authorization API	The CMS-required standards-based API that supports electronic submission, status inquiry, documentation exchange, determination notification, and related communications associated with prior authorization requests. The API also supports required reporting and interoperability functions established by CMS.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

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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.
SMART on FHIR	An industry-standard framework that provides secure authorization and authentication for applications accessing FHIR APIs through standardized identity management and access controls. SMART on FHIR enables secure interoperability while protecting Member privacy and maintaining appropriate authorization.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.
Third-Party Application	A software application selected and authorized by a Member to electronically retrieve health information from CalOptima Health through a standards-based API. Third-party applications may not be subject to HIPAA once information is disclosed to them. CalOptima Health shall provide Members with required educational information regarding the privacy and security risks associated with authorizing third-party applications.
United States Core Data for Interoperability (USCDI)	The standardized set of health data classes and constituent data elements adopted by the Office of the National Coordinator for Health Information Technology (ONC) for nationwide interoperable exchange of electronic health information. CalOptima Health shall implement the USCDI version adopted by federal regulation and updated by CMS, ONC, or DHCS.

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Policy:	HH.3023
Title:	**Information Sharing**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	10/05/2023
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy establishes CalOptima Health's governance for the collection, use, disclosure, exchange, and electronic availability of Protected Health Information (PHI), Personally Identifiable Information (PII), and United States Core Data for Interoperability (USCDI) through health information exchanges (HIEs), Application Programming Interfaces (APIs), the California Data Exchange Framework (DxF), and other interoperable technologies. This policy also establishes requirements for compliance with federal interoperability requirements, including Patient Access APIs, Provider Access APIs, Payer-to-Payer APIs, Prior Authorization APIs, and information exchange requirements established by the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). This policy outlines CalOptima Health's process for sharing information with participating First Tier, Downstream, and Related Entities (FDRs), local health jurisdictions, county and public agencies, and other MCPs to coordinate Medicare and Medi-Cal Covered Services. It also governs the disclosure of PHI necessary for calculating, validating, auditing, and paying the DHCS Directed Payment Initiative and alternate payment methodology programs.

II. POLICY

A. CalOptima Health shall participate in data sharing exchanges, such as health information exchanges and community information exchanges, that permit the sharing of Personally Identifiable Information (PII) and/or Protected Health Information (PHI), as defined by the California Health and Human Services Data Exchange Framework (DxF) and in accordance with Health & Safety (H&S) Code section 130290. CalOptima Health shall comply with federal and state privacy laws and each data sharing agreement, as applicable.

CalOptima Health shall implement and maintain standards-based interoperability capabilities using HL7® FHIR® APIs, consistent with CMS interoperability regulations, DHCS guidance, and applicable ONC certification requirements. APIs shall support secure electronic exchange of health information between Members, Providers, other payers, and authorized third-party applications.

1. CalOptima Health may disclose PHI to Providers, DHCS, and DHCS designated contractors without Member authorization when such disclosure is necessary for payment, healthcare operations, quality measurement, rate calculation and validation of Directed Payment Initiative and alternate payment methodology programs, as required by DHCS.

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B. CalOptima Health timely executed the DxF Data Sharing Agreement (DSA) before January 31, 2023. By January 31, 2024, exchanged health and social services information or provide access to health information as specified in the DSA and its policies and procedures.

C. CalOptima Health shall integrate disparate information to support the California Advancing and Innovating Medi-Cal (CalAIM) and Population Health Management (PHM) programs by performing key PHM functions and providing authorized users with access to timely, accurate, and comprehensive data on Member's health history and needs.

D. CalOptima Health interoperability shall enhance PHM services, in support of population health principals, integrated care and care coordination across delivery systems.

E. CalOptima Health shall integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members.

F. CalOptima Health shall exchange United States Core Data for Interoperability (USCDI) using federally adopted interoperability standards, including HL7® FHIR®, and shall implement updated USCDI versions as required by CMS, ONC, or DHCS. Information exchanged shall include all data elements required under applicable interoperability regulations, including claims, encounters, clinical data, laboratory results, prior authorization information, and provider directory information, where applicable.

G. CalOptima Health shall exchange necessary data to implement Continuity of Care (CoC) protections. CalOptima Health shall complete all data sharing requirements as a previous MCP or a receiving MCP, as applicable, as specified in the 2024 DHCS Medi-Cal Managed Care Plan Transition Policy Guide, Section VIII. Continuity of Care Data Sharing Policy. CalOptima Health shall implement and maintain: Patient Access API, Provider Access API, Payer-to-Payer API, Prior Authorization API. APIs shall utilize nationally recognized interoperability standards including HL7® FHIR®, SMART on FHIR, OAuth 2.0 authentication, and any implementation guides adopted by CMS or DHCS. CalOptima Health shall monitor API availability, security, performance, audit logging, and compliance with applicable interoperability requirements.

H. CalOptima Health shall provide the DHCS with administrative, clinical, and other data requirements as specified by DHCS when requested.

I. CalOptima Health shall not disclose PII/PHI unless permitted or required by applicable law Disclosure of PII/PHI for treatment, payment, and/or health care operations, quality measurement, and Directed Payment Initiative or alternate payment methodology programs shall not require Member authorization where permitted by HIPAA and mandated by DHCS. CalOptima Health may disclose PHI through CMS-required interoperability APIs without Member Authorization when such disclosure is expressly permitted or required under HIPAA, CMS interoperability regulations, applicable Medicaid regulations, or DHCS guidance. Member-directed disclosures through the Patient Access API shall be made in accordance with federal interoperability requirements.

J. CalOptima Health shall adhere to stricter patient confidentiality laws when it applies and, when applicable, the federal substance use disorder confidentiality regulation, 42 CFR Part 2. CalOptima Health shall disclose behavioral health and substance use disorder PHI, including 42 CFR Part 2 data, when legally permissible for payment, healthcare operations, quality measurement, and Directed Payment Initiative validation. Disclosures under this section shall be limited to the minimum necessary PHI required to calculate, validate, audit, or reconcile the applicable quality measure or payment. Electronic exchange of Part 2 records shall utilize appropriate data

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segmentation and access controls to ensure compliance with applicable federal confidentiality requirements while supporting interoperable exchange where legally permitted.

K. When information may be shared under HIPAA and other applicable laws, CalOptima Health may share only the minimum information necessary to accomplish the purpose of the disclosure, pursuant to CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

1. For Directed Payment Initiative and quality measure disclosures, the HIPAA minimum necessary standard shall be defined by the DHCS-specified numerator, denominator, and measure specifications. CalOptima Health shall not limit disclosures based on primary care assignment, attribution, or internal segmentation where the DHCS-defined denominator includes additional Members. The HIPAA Minimum Necessary Standard shall not apply to disclosures made directly to the Member through the CMS-required Patient Access API or other disclosures where the Minimum Necessary Standard does not apply under HIPAA. Minimum Necessary requirements shall continue to apply to treatment, payment, health care operations, quality measurement, and other disclosures unless otherwise permitted by law.

L. Where a Business Associate Agreement (BAA) applies, CalOptima Health's BAA template must be effectuated before sharing PII and/or PHI with an external party, pursuant to CalOptima Health Policy HH.3022: Business Associate Agreements.

M. A Member may request to restrict or limit information sharing in accordance with applicable statutory, regulatory, and contractual requirements, as permissible under CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information.

N. Members shall have the ability to electronically access required health information through standards-based APIs consistent with CMS interoperability regulations. Members may authorize third-party applications to retrieve their information. CalOptima Health shall provide Members with educational information regarding the privacy and security risks associated with third-party applications that are not covered entities or business associates under HIPAA.

O. CalOptima Health shall not engage in practices that are likely to interfere with, prevent, materially discourage, or otherwise inhibit lawful access, exchange, or use of electronic health information except where an exception under applicable federal law applies. Decisions to deny or delay electronic information exchange shall be documented and supported by an applicable legal or regulatory exception.

III. PROCEDURE

A. As a Previous MCP, CalOptima Health shall transmit utilization data, authorization data, Member information, including preferred form of communication, accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to receiving MCPs, in accordance with the CoC Data Sharing Policy.

B. Where technically feasible, ECM information shall be exchanged through standards-based electronic interfaces consistent with CMS interoperability requirements and the California Data Exchange Framework. CalOptima Health shall provide the following information to Enhanced Care Management (ECM) Providers:

1. Member assignment files, which include listing of Members authorized and assigned to the ECM Provider;

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2. Historical encounters/claims data for assigned Members;

3. Physical, behavioral and administrative information, and information indicating Member Social Drivers of Health (SDOH) needs;

4. Reports of performance on quality measures, as requested.

C. Admission, Discharge, and Transfer (ADT) information

1. CalOptima Health shall require contracted Hospitals and Skilled Nursing Facilities (SNFs) to provide timely notifications of Member admissions, discharges, and/or transfers (ADT). Hospital and SNF information shall be exchanged in shared information systems.

2. CalOptima Health shall maintain contracts with vendors to supply ADT messages in support of this policy.

   a. Hospitals shall notify CalOptima Health of ADT information either immediately, prior to, or at the time of the Member's discharge or transfer from the Hospital's inpatient services.

   b. For SNF admissions, the SNF shall notify CalOptima Health within 48 hours of admission.

   c. For SNF discharges or transfers, the SNF shall notify CalOptima Health in advance if at all possible, or at the time of the discharge or transfer.

3. CalOptima Health shall ensure that data exchanged is appropriately linked to the correct, real person.

4. ADT information shall be made available through interoperable systems supporting continuity of Care, care coordination, and Provider Access API requirements where applicable.

D. For mandatory data disclosures, CalOptima Health shall provide Providers and DHCS designated contractors with the following PHI and administrative data when required to support quality measure and Directed Payment Initiative programs:

1. ADT feeds via DxF Qualified Health Information Organizations in real time;

2. Enrollment files and rosters within seven (7) calendar days of request;

3. Pharmacy claims, including behavioral health medications, within fourteen (14) calendar days;

4. Professional, facility, and behavioral health claims, including Part 2 data where legally permissible, within thirty (30) calendar days; and

5. Quality measure rates, numerators, denominators, and underlying data within forty-five (45) calendar days.

6. Any other PHI or administrative data required by DHCS/APL 25-015: Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs. Prior Authorization status information, including requests, determinations, supporting documentation, and decision rationale, shall be made available through the Prior Authorization API consistent with CMS interoperability requirements.

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E. CalOptima Health shall maintain a formal dispute resolution process for Provider to challenge data, quality measure calculations, and performance rates. When a Provider requests Member-level PHI to validate or dispute a measure, CalOptima Health shall disclose the PHI necessary to reproduce the calculation.

F. CalOptima Health shall ensure that all subcontractors, vendors, and downstream entities comply with the PHI disclosure and quality data requirement of applicable DHCS All Plan Letters (APLs), including but not limited to, APL 25-015: Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs. The Delegation of data functions does not relieve CalOptima Health of responsibility.

G. In accordance with all NCQA PHM standards, CalOptima Health shall exchange the following data to ensure the ability to assess the needs of all Members:

1. Medical and behavioral claims or encounters;
2. Pharmacy claims;
3. Laboratory results;
4. Health appraisal status;
5. Electronic health records; and
6. Health services programs within the organization

H. In accordance with California Penal Code Section 4011.11, disclosure of PII is permitted if the disclosure is:

1. Reasonably necessary to facilitate a county jail or youth correctional inmate's enrollment in CalOptima Health;
2. Reasonably necessary to facilitate a county jail or youth correctional inmate's behavioral health treatment post-release; and
3. Complies with federal laws.

I. External data sharing requests shall undergo CalOptima Health's data sharing review procedure.

J. Prior Authorization status information, including requests, determinations, supporting documentation, and decision rationale, shall be made available through the Prior Authorization API consistent with CMS interoperability requirements.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

1. 2024 Department of Healthcare Services (DHCS) Medi-Cal Managed Care Plan Transition Policy Guide, March 22, 2024
2. 21st Century Cures Act, Information Blocking Rule, 45 CFR Part 171.
3. CalAIM Enhanced Care Management Policy Guide, August 2024

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4. CalAIM Data Sharing Authorization Guidance, October 2025
5. CalAIM D-SNP Policy Guide, September 2025
6. CalAIM Population Health Management Policy Guide, July 2025
7. California Health and Human Services Data Exchange Framework: Single Data Sharing Agreement
8. California Health & Safety Code §130290 (Data Exchange Framework).
9. California Penal Code Section 4011.11
10. CalOptima Health Contract with Department of Health Care Services (DHCS)
11. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
12. CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information
13. CalOptima Health Policy HH.3022: Business Associate Agreements
14. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).
15. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)
16. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-018: Managed Care Health Plan Transition Policy Guide
17. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-015: Data Sharing and Quality Rate Production for Directed Payment Initiatives and Alternative Payment Methodology Programs
18. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-008: Interoperability Final Rules, Including Prior Authorization Requirements (Supersedes APL 22-026)
19. Title 45, Code of Federal Regulations (CFR), Parts 160, 164 and 170, §§170.213 & 170.315

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/05/2023	HH.3023	Information Sharing	Medi-Cal OneCare
Revised	10/01/2024	HH.3023	Information Sharing	Medi-Cal OneCare
Revised	11/01/2025	HH.3023	Information Sharing	Medi-Cal OneCare
Revised	02/01/2026	HH.3023	Information Sharing	Medi-Cal OneCare
Revised		HH.3023	Information Sharing	Covered California Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Application Programming Interface (API)	A standardized set of technical specifications and protocols that allows separate software applications to securely communicate, exchange, and retrieve electronic health information without requiring direct access to another system's underlying database. For purposes of this policy, APIs include CMS-required Patient Access, Provider Access, Payer-to-Payer, and Prior Authorization APIs.
California Data Exchange Framework (DxF)	California's statewide data-sharing framework established under Health and Safety Code section 130290 to promote secure, standardized exchange of health and social services information among participating entities.
Continuity of Care	Covered California: Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship. Medi-Cal: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing, and home health care.
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: 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,

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For 202611

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 DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Directed Payment Initiative	A payment arrangement that directs certain expenditures made by CalOptima Health under its contract with DHCS for Medi-Cal Services and that is either approved by CMS as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Electronic Health Information (EHI)	Electronic protected health information that is included within the data classes and elements adopted by the Office of the National Coordinator for Health Information Technology and is maintained in electronic form by or for CalOptima Health. The scope of EHI shall be interpreted consistent with applicable ONC regulations.
Enhanced Care Management (ECM) Provider	A Provider within the community that have a contractual relationship with CalOptima Health (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus.

For 2026 1105 BOD Review Only

Term	Definition
Fast Healthcare Interoperability Resources (FHIR)	The Health Level Seven International (HL7®) interoperability standard adopted by the Office of the National Coordinator for Health Information Technology (ONC) for the secure electronic exchange of health information through standardized APIs. FHIR establishes common data formats and technical specifications that enable health information to be exchanged between health plans, providers, Members, and authorized third-party applications.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Health Information Exchange (HIE)	An organization or technology platform that enables the secure electronic exchange of health information among participating health care organizations, health plans, public health agencies, and other authorized entities in accordance with applicable federal and state law.
Interoperability	The capability of different information systems, devices, applications, or organizations to securely access, exchange, integrate, and use electronic health information in a coordinated manner that supports clinical care, care coordination, payment, public health, and health care operations. Interoperability includes the use of nationally recognized technical standards adopted by CMS, ONC, DHCS, or other applicable regulatory authorities.
Member	An individual enrolled in a CalOptima Health program.
OAuth 2.0	The industry-standard authorization framework used to authenticate and authorize secure access to interoperability APIs without requiring Members or Providers to disclose system passwords to third-party applications. OAuth supports secure delegated access to electronic health information.
Patient Access API	The federally required standards-based API that enables Members to securely access their health information electronically using applications of their choice, consistent with applicable federal and state law. Information available through the Patient Access API includes, as applicable: • Claims • Encounters • Clinical information • Laboratory results • Provider directory information • Prior authorization information • Other data required under CMS interoperability regulations.

For 20261105 BOD Review Only

Term	Definition
Provider Access API	The CMS-required standards-based API that enables participating contracted Providers with a treatment relationship to electronically access Member health information necessary for treatment and care coordination, subject to applicable privacy and security requirements. Information exchanged shall be limited to data required under applicable CMS regulations and DHCS guidance.
Payer-to-Payer API	The CMS-required standards-based API that enables electronic exchange of a Member's health information between impacted payers, upon the Member's request, to facilitate continuity of care and reduce administrative burden when Members change health plans.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including: 1. Any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and 2. Any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information
Previous Managed Care Plan (MCP)	Previous MCP is the plan a member was enrolled in prior to transitioning to a new MCP.
Prior Authorization API	The CMS-required standards-based API that supports electronic submission, status inquiry, documentation exchange, determination notification, and related communications associated with prior authorization requests. The API also supports required reporting and interoperability functions established by CMS.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

For 20261105 BOD Review Only

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.
SMART on FHIR	An industry-standard framework that provides secure authorization and authentication for applications accessing FHIR APIs through standardized identity management and access controls. SMART on FHIR enables secure interoperability while protecting Member privacy and maintaining appropriate authorization.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.
Third-Party Application	A software application selected and authorized by a Member to electronically retrieve health information from CalOptima Health through a standards-based API. Third-party applications may not be subject to HIPAA once information is disclosed to them. CalOptima Health shall provide Members with required educational information regarding the privacy and security risks associated with authorizing third-party applications.
United States Core Data for Interoperability (USCDI)	The standardized set of health data classes and constituent data elements adopted by the Office of the National Coordinator for Health Information Technology (ONC) for nationwide interoperable exchange of electronic health information. CalOptima Health shall implement the USCDI version adopted by federal regulation and updated by CMS, ONC, or DHCS.

1

For 20261105 BOD Review Only

Policy:	HH.4003
Title:	**Annual Risk Assessment (Internal)**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy describes the internal Annual Risk Assessment process conducted by the CalOptima Health Internal Audit Department (IAD) to identify specific areas vulnerable to potential compliance risk. Such areas are documented in CalOptima Health's Annual Risk Assessment Tool, which will influence the development of CalOptima Health's Internal Audit and Monitoring Work Plan.

II. POLICY

A. The Internal Audit Department (IAD) is responsible for completing a risk assessment, at least annually, to develop its Internal Audit and Monitoring Plan that provides a comprehensive assessment of CalOptima Health. In assessing risk, the Internal Audit Department shall consider the following:

1. Statutory, regulatory, and contractual compliance standards;

2. CalOptima Health's policies and procedures;

3. Business impact on Member care;

4. Stakeholder audits (DHCS and CMS) CAPs;

5. Consultant mock audits;

~~4.~~6. Past compliance issues (e.g., CAPs, Regulator Notices); ~~and~~

7. Chiefs/Executive Directors/Business Areas Risk Assessment Questionnaires; and

~~5.~~8. Compliance dashboard results.

B. The Internal Audit Department shall stay current with all regulatory communication and guidance from Regulatory Agencies.

C. The Annual Risk Assessment shall cover a twelve (12)-month lookback period with an end date

Back to Agenda Back to Item

within three (3) months of the initiation of Risk Assessment Questionnaires.

~~C.~~D. The Internal Audit Department shall present Annual Risk Assessment results and the proposed Internal Audit and Monitoring Work Plan to the Compliance Committee for review and approval by the end of the calendar year to be effective for the following calendar year.

III. PROCEDURE

A. The Internal Audit Department shall schedule meetings with all operational department leads to complete the assessment.

1. Discovery and Analysis. The Internal Audit Department shall undertake a discovery process to determine which regulatory, statutory, contractual, and CalOptima Health policy requirements are completely implemented, their operational effectiveness, and how the practices and the documentation support compliance. The discovery process shall consist of document review, an interview process, and review of other relevant information. The analysis component of risk assessment is based on the evaluation of the data from the business area.

   a. In order to determine whether there are accurate and compliant processes and systems in place, the Internal Audit Department shall conduct the following activities:

      i. A review of CalOptima Health policies and procedures and other supporting documents, such as regulatory communications. For each internal area reviewed in the risk assessment process, the Internal Audit Department shall request from the applicable department the policies and procedures and supporting documentation that describe processes used to meet regulatory requirements. The Internal Audit Department shall evaluate the documents for compliance.

      ii. Conduct interrogatory or in-person interviews with internal functional area department management and relevant support staff to discuss the following:

         a) Processes that are supported by policies and procedures and other relevant documentation;

         b) Changes in laws, or regulations, in the previous year that impact their area;

         c) Changes in management and staffing;

         d) The degree to which the activities conducted by their area are subject to compliance risk from the standpoint of State and Federal regulatory requirements.

         e) The degree to which the activities conducted by their area impact CalOptima Health Members; and

         f) Material changes in processes that are expected to impact the functional areas.

B. The Internal Audit Department shall review the following information for internal areas, and the appropriate operational department shall review the following information as part of the risk assessment process:

1. Regulatory Agencies identify a particular area as problematic through enforcement actions, CalOptima Health Audit findings, notices of non-compliance, etc.;

For 20261105 BOD Review Only

2. Whether ~~there is~~ a Corrective Action Plan (CAP) has been in effect over the lookback period, and if so, its relative risk for the non-compliant area; and

3. CalOptima Health's Star Ratings scores for specific requirements, to be populated as applicable.

C. To validate compliance of the staff interviews, and review of other relevant information, the Internal Audit Department shall rely on data gathered using the Annual Risk Assessment, and conduct baseline risk assessment Audits evaluating file reviews, data collected from annual Audit results, and number of CAPs issued during the review period.

1. ~~1.~~ As data-driven analysis is significant to determine functional area risk to Members, the Internal Audit Department shall compile the data and then ranks the risks based on the greatest impact.

2. A risk taxonomy shall be developed based on aggregate risk scores for each internal Business Area. Business Area aggregate risk scores shall be ranked highest to lowest, with higher scores representing greater relative risk than lower scores.

D. The Internal Audit Department shall prioritize ~~those~~Business Areas with greatest risk when developing the annual Audit and Monitoring Work Plan.

E. Upon completion, the results of the internal Annual Risk Assessment are presented to the Compliance Committee.

~~E.~~F. The Internal Audit Department shall ~~present~~implement the ~~internal risk assessment~~Annual Risk Assessment results and proposed Audit and Monitoring Work Plan following approval by the Compliance Committee.

~~F.~~G. The Internal Audit Department shall re-evaluate the risk plan based on internal changes (e.g., staffing and organizational structure changes, internal ~~Audit~~audit results, ~~Monitoring~~monitoring results~~) and~~), external changes (e.g., regulatory changes, marketplace changes, regulatory agency Audits results), and newly identified priorities (e.g., from CalOptima Health or Office of Compliance leadership).

~~G. Upon completion, the results of the internal risk assessment are presented to the Compliance Committee.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

For 20261105 BOD Review Only

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/07/2017	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/06/2018	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/05/2019	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/03/2020	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/20/2021	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/31/2022	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	10/05/2023	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	11/07/2024	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	11/01/2025	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised		HH.4003	Annual Risk Assessment (Internal)	Administrative

For 20261

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, resulting in unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being Audited and normally performed by individuals with one of several acknowledged certifications.
Annual Risk Assessment	A screening to stratify level of risk (high, medium, low) based upon vulnerability to potential non-compliance within applicable policies and procedures, regulatory standards, and contractual obligations. The risk assessment includes a questionnaire with ratings and comments about actions that can be taken to reduce risks, maintain compliance, and prevent deficiencies. A risk assessment should be performed at least annually.
Business Area	CalOptima Health internal departments and controlled sub-functions under the management and oversight of a department Director, Executive Director, or Chief Executive.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Corrective Action Plan (CAP)	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), 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.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

For 2026 10/5 BOD Review Only

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the Audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Regulatory Agencies	For the purposes of this policy, Regulatory Agencies include Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Office of Inspector General (OIG), and Office of Civil Rights (OCR).
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

For 20261105 BOD Review Only

Policy:	HH.4003
Title:	**Annual Risk Assessment (Internal)**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy describes the internal Annual Risk Assessment process conducted by the CalOptima Health Internal Audit Department (IAD) to identify specific areas vulnerable to potential compliance risk. Such areas are documented in CalOptima Health's Annual Risk Assessment Tool, which will influence the development of CalOptima Health's Internal Audit and Monitoring Work Plan.

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6. Past compliance issues (e.g., CAPs, Regulator Notices);
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8. Compliance dashboard results.

B. The Internal Audit Department shall stay current with all regulatory communication and guidance from Regulatory Agencies.

C. The Annual Risk Assessment shall cover a twelve (12)-month lookback period with an end date

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For 20261105 BOD Review Only

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
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12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors

For 20261105 BOD Review Only

12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
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VIII. REVISION HISTORY

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Revised	12/05/2019	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/03/2020	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/20/2021	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	12/31/2022	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	10/05/2023	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	11/07/2024	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised	11/01/2025	HH.4003	Annual Risk Assessment (Internal)	Administrative
Revised		HH.4003	Annual Risk Assessment (Internal)	Administrative

For 20261105 BOD

IX. GLOSSARY

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Abuse	Actions that may, directly or indirectly, resulting in unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
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Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Corrective Action Plan (CAP)	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), 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.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

For 2026 10/5 BOD Review Only

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the Audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Regulatory Agencies	For the purposes of this policy, Regulatory Agencies include Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Office of Inspector General (OIG), and Office of Civil Rights (OCR).
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

For 20261105 BOD Review Only

Policy:	HH.4004
Title:	**Grant Audits/Reviews**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	01/01/2025
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

The purpose of ~~a~~ Grant Audits and Reviews are to provide independent and objective assurance that Grant funds are managed in accordance with applicable laws, regulations, and award requirements through Internal Controls in place to ensure the efficient, effective, and compliant use of funds. These internal reviews and audits promote transparency, accountability, and responsible stewardship of public and grantor resources.

II. POLICY

A. The objective of ~~a~~ Grant Audits and Reviews are to provide oversight to reassure CalOptima Health's Board and management to ensure compliance with Grant Award requirements and appropriate use of funds. This includes evaluating whether:

1. Grant expenditures are allowable, allocable, and reasonable under the Grant Award requirements, applicable laws and regulations, and ~~promoting~~promote effective~~,~~ and reasonable~~, and cost effective~~ Internal Controls.

2. Funds are used in accordance with the terms and conditions of the Grant Agreement.

3. Internal Controls support accurate and appropriate financial and performance reporting.

4. There is adequate oversight to prevent and detect fraud or waste.

5. Grant Objectives are being achieved in a manner consistent with Grantor expectations and CalOptima Health's policies, procedures, and a Grant Agreement.

6. Grant Management reporting is operating as an effective Internal Control.

7. Conducting special examinations and reviews upon the completion of Board approved Grants, or on an interim basis as needed.

8. Appropriate policies, procedures and industry best practices are present and being followed.

9. The use of Grant funding resources and recommending improvements in policy, procedures, and operations. In addition, the Internal Audit Department will be recommending the best practices and enhancements for Internal Controls that includes desktop procedures for Grant funds.

B. These internal audits are conducted in alignment with the Institute of Internal Auditors (IIA) Global Internal Audit Standards to provide independent assurance to the Board, management, grantors, and stakeholders responsible for Grant funding. These standards ensure that Grant internal audits are performed with integrity, objectivity, and professional competence. Internal Audit activities follow a risk-based approach and will include sufficient and appropriate procedures to support any conclusions or recommendations provided in Audit Reports.

C. Grants shall be established and administered in accordance with CalOptima Health Policy AA.1400: Grant Management.

D. Post-Award Grant Close-out occurs at the end of the Grant lifecycle at which point the awarding entity, CalOptima Health, determines that the Grantee has completed all applicable administrative actions. Grant Close-out Review is the final stage of the Grant Management process and is performed by the Sponsoring Department. Grant Close-out Review is achieved upon completion of:

1. Completion of all provisions and requirements outlined in the Grant Award Agreement, including all Attachments, Addendums, Extensions, and Modifications.

2. Issuance of a Grant Close-out Letter from the Sponsoring Department to the Grantee.

3. Grant Close-out Review as required by CalOptima Health Policy AA.1400: Grant Management.

E. Internal Audit Opinion Policy for Grant Auditing

1. In accordance with the IIA's Global Internal Audit Standards, internal Audit Reports for Grant-related engagements may include the following opinions or assessments:

a. Formal Opinion: A formal opinion is issued when sufficient, appropriate evidence has been obtained. This opinion will assess the effectiveness of Internal Controls, compliance with Grant requirements, and level of residual risk. Typical opinion descriptors include:

i. Adequate;

ii. Needs Improvement;

iii. Unsatisfactory; and/or

iv. Low / Moderate / High-Risk.

b. Narrative Assessment: If the engagement scope is limited or data is insufficient, the report may present descriptive findings and risks without issuing a formal opinion.

c. No Opinion: If the audit cannot be completed due to scope limitations or lack of evidence, the report will clearly state that no opinion is provided and disclose the reasons for the limitation.

III. PROCEDURE

A. Upon completion of the Grant Close-out Review, a Grant Audit may be performed to validate the attainment of financial and Grant Objectives as documented in the Grant Award Agreement and Grant Close-out Review.

1. Grants with aggregate payments of $50,000 or more shall be audited. Grants under $50,000 with incomplete or non-existent Grant Close-out Review documentation may also be selected for audit.

For 20261105 BOD Review Only

2. The Sponsoring Department shall provide a copy of the final Grant Close-out Review to CalOptima Health's Internal Audit department within thirty (30) calendar days of receiving it.

3. The Sponsoring Department shall provide the following documentary evidence to the Internal Audit Department within sixty (60) calendar days of completing the final Grant Close-out Review.

   a. CalOptima Health Board Action Request (COBAR) authorizing Grant or Grant Program.

   b. Internal presentations of the Grant or Grant Program to CalOptima Health's leadership.

   c. Sponsoring Department's Notice of Funding Opportunity (NOFO) document.

   d. Grant Application, including evidence of approval by the Evaluation Committee.

   e. Grant Approval Letter from the Sponsoring Department to the Grantee.

   f. Signed Grant Award Agreement, including all Addendums, Amendments, and Extensions.

   g. Evidence of Grantee's California DOJ Registry Status indicating a "Current" status.

   h. Periodic Progress Reports and Final Report as outlined in the Grant Award Agreement, including evidence of review and approval.

   i. Grant Budget and financial reporting, including supportive evidence such as invoices, etc.

   j. Audited Financial Statements, including Single Audits, if any, for the relevant Grant Term. Financial Statements should include supporting schedules of donor-restricted Net Assets.

   k. IRS Form 990 tax filing throughout the relevant Grant Term.

   l. Copies of all Check Requests and payments from CalOptima Health's Finance Department to the Grantee, including evidence of deposit by the Grantee.

   m. Internal newsletters, photographic material, or management reporting evidencing Grantee's attainment of the Grant Objectives as outlined in the Grant Award Agreement.

   n. Evidence that unspent Grant funds were recouped.

   o. Grant Close-out Letter issued by the Sponsoring Department to Grantee.

   p. The Internal Audit Department may request additional evidence directly from the Grantee.

4. Collection of evidence and supporting documentation needed to complete Grant audit/review:

   ~~4.~~a. The Sponsoring Department shall coordinate the collection of all relevant records for the audit, review such records, and provide records to the Internal Audit Department in a timely manner.

   b. The Internal Audit Department may request evidence or other supporting documentation directly from the Grantee.

   c. The Sponsoring Department shall support and assist the Internal Audit Department's efforts to collect responses, evidence and supporting documentation from the Grantee, if necessary.

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5. The Internal Audit Department shall design each Scope of Audit using a risk-based approach to align with the IIA Global Internal Audit Standards to ensure that Grant Objectives were achieved as reported and funds were appropriately used for their intended purpose. The Scope of Audit shall include and assess the following activities:

    a. Audit checklist of required documents and approvals.

    b. Complete and accurate fulfillment of the Grant Management process.

    c. The Grantee's obligations were completed according to the Grant Award Agreement.

    d. Grant expenditures are appropriately tied to the Grant Budget, aligned with the Grant Objectives, and supported by appropriate and legitimate documentation.

    e. Grant funds were wholly used for the Grant's intended purpose without any evidence of fraud, waste or abuse.

    f. Unused Grant funds were wholly refunded to CalOptima Health.

    g. Grant Close-out Review completed with a Final Report to CalOptima Health's leadership.

    h. The Scope of Audit may be as broad or restricted as required to meet the organization's needs.

6. ~~The Grant Audit~~Planning shall ~~begin~~commence within ~~sixty (60) calendar~~thirty (30) days of receiving ~~the~~a complete Grant Close-Out Review ~~and~~ package of documentation and information from CalOptima Health Grants Management, the Sponsoring Department, and Grantee. If documentation remains incomplete after sixty (60) days, the Internal Audit Department may initiate a focused Review or request a Corrective Action Plan (CAP) from CalOptima Health Grants Management and/or the Sponsoring Department in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

7. Grant Audit/Review fieldwork will conclude within the following targeted timeframes:

    a. Grant Review: sixty (60) to one hundred and twenty (120) days after initial engagement.

    b. Grant Audit: ninety (90) ~~calendar days of beginning the~~to one hundred and eighty (180) days after initial engagement.

    ~~6.~~c. Timeframes may be adjusted due to delays in receiving audit deliverables, coordination of resources, conflicting workloads, or other unforeseen circumstances.

8. All Expenditures and Subcontracting must be authorized and tied to the purpose of the Grant.

    a. Expenditures are unallowable when they:

        i. Are not included in the approved Grant Budget.

        ii. Lack sufficient evidence or other supporting documentation.

        iii. Fall outside the Objectives of the Grant or Term of the Grant.

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iv. Violate the terms and conditions of the Grant Award Agreement.

b. Subcontracting is unallowable when:

i. The Grantee uses a Subcontractor not approved in writing by CalOptima Health.

ii. The activity performed was not permitted under the Grant Award Agreement.

iii. The Grantee failed to disclose the Subcontractor in the Grant Application or subsequent approvals.

c. When potential unallowable Expenditures and/or Subcontracting are identified, the Internal Audit Department shall:

i. Document the issue in the audit working papers with supporting evidence (e.g., invoices, receipts, contracts, financial reports, or any notes to the contrary).

ii. Determine whether the issue is isolated or systemic based on the Scope of Audit defined in Section III.A.5 of this Policy.

iii. Document any observations of unallowable Expenditures and Subcontracting in the Audit Report per Section III.A.8 of this Policy.

iv. Quantify all suspected unallowable Expenditures and Subcontracting in the Audit Report for review and possible recovery by CalOptima Health Grants Management.

v. Report any suspected fraud, waste, or abuse (FWA) to the Office of Compliance in accordance with CalOptima Health Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting.

~~7.~~9. Upon completion of the Grant Audit or Review, the Internal Audit Department shall provide a report to CalOptima Health's Chief ~~Operating~~Compliance Officer~~, Chief Compliance Officer, and the Grant's Sponsoring Department.~~ and Grant Management.. The Audit Report shall include the following:

a. Executive Summary;

b. General Information;

c. Participants;

d. Definitions;

e. Scope, Activities, and Methodology;

f. Documents and Evidence Reviewed;

g. Observations;

h. Recommendations; and

i. Conclusions: The Audit Report shall contain an opinion concerning the overall adequacy of controls, operational procedures, and outcomes.

For 20261105 BOD Review Only

~~8.~~10. The Internal Audit Department will coordinate with and inform management of the results of all audits, the submission of audit responses, and implementation of audit recommendations.

~~9.~~11. The Internal Auditor Department may report the status of completed audits to the Compliance Committee. The Internal Audit Department will also submit written updates directly to the Committee Chairperson as they are completed throughout the quarter.

~~10.~~12. Observations, Findings, or Conclusions could result in a request for a Corrective Action Plan. Corrective Action Plans shall be administered in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

~~11.~~13. The Chief Compliance Officer may choose to outsource any or all functions of the Grant Audit and appoint the Director of the Internal Audit Department to facilitate all communications and audit work with the engaged external auditor. Supplemental Grant Audits may be contracted to perform independent validation and audit procedures, which would primarily leverage/review the audit work performed by the Internal Audit Department.

~~12.~~14. Objectivity is essential to the Grant Audit process. Internal Audit Department personnel shall avoid actual and apparent conflicts of interest. Internal Audit Department personnel should not be involved in the development and installation of any Grant systems or procedures, preparation of records, or other activities that the Internal Audit staff may review or appraise that could be subject to a Grant Audit. Internal Audit personnel may be consulted on the design or adequacy of controls incorporated into new systems and procedures or on revisions to existing systems.

~~13.~~15. Grant Audits shall be performed with absolute independence and control over the audit work. Friendships, personal or business relations, reputations, outside influence, or other factors must not be allowed to alter the Scope of Audit or outcomes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1400: Grant Management
B. CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
~~B.~~C. CalOptima Health Policy HH.2005: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/06/2025	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

For 20261105 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	HH.4004	Grant Auditing	Administrative
Revised	11/01/2025	HH.4004	Grant Audits/Reviews	Administrative
Revised		HH.4004	Grant Audits/Reviews	Administrative

For 20261105 BOD Review Only

IX. GLOSSARY

Term	Definition
Audit Report	Formal written opinion issued by an independent auditor as an assurance service in order to make decisions based on results and conclusions derived from the audit.
Check Request	A warrant device authorizing payment to a designated beneficiary on demand or after a specific date.
Corrective Action Plan	Step-by-step plan that outlines how to address issues and deficiencies in a program or process. The goal of a CAP is to resolve issues and improve operations and processes.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health's Grants Management department to review and assess Grant Applications and program proposals.
Expenditures	Authorized spending of the Grant Award funds to support the Grant's Objectives. Expenditures include costs that are directly and indirectly tied to the purpose of the Grant (e.g. salaries, benefits, consultants, equipment, facilities, supplies, training, etc.).
Final Report	Document providing information about the Grant project or program's final progress in achieving the goals and objectives of the Grant provided by the Grantee to CalOptima Health. The schedule of submission is set in the Grant Award Agreement.
Financial Statements	Written records that summarize a company's financial activities and position over a specific period of time. They are used to assess an organization's financial health and help with decision-making.
Grant	Financial award given by CalOptima Health to an eligible recipient to achieve a particular purpose or project. Grants are generally not expected to be repaid by the recipient when appropriately used for an approved Grant project.
Grant Application	An application submitted by a Grant applicant to CalOptima Health and used to formally request funding for a specific project.
Grant Approval Letter	Written document informing a Grantee that the Grant Application they submitted has been approved.
Grant Audit/ Review	An independent and comprehensive review of a Grant after close-out to ensure that Grant funds were used in accordance with the Grant Award Agreement's terms and conditions. A Grant Review is generally smaller in scope and seeks to provide a fast track validation of specific activities, achievements, and/or expenditures of the Grant.
Grant Award	The total dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grant Award Agreement	Funding agreement between CalOptima Health and the Grantee that sets the terms, conditions, and requirements of a Grant.
Grant Budget	Financial plan that outlines the estimated expenses and income for a project or program that is seeking funding. A Grant budget demonstrates how Grant funds will be used to achieve the project's goals and objectives.
Grant Close-out Letter	A written document that informs the Grantee that all requirements of the Grant have been fulfilled and that the Grant Term has concluded.
Grant Close-out Review	The process by which the awarding entity determines that all required work and administrative actions for a Grant have been completed. It's the final phase of a Grant's lifecycle and marks the end of the awarding entity's relationship with the Grantee.
Grant Management	CalOptima Health's Sponsoring Department's overall exercise of Grant administration throughout the phases of pre-award, award, post-award, and close-out.
Grant Objectives	Statements and milestones that describe the intended outcomes of a Grant-funded project or program.
Grant Program	Funding mechanism to award single or multiple Grants in service to common projects and ideas that support the community as stated in the Notice of Funding Opportunity.
Grant Term	The duration of time in which the Grantee is expected to achieve the Grant's goals and objectives as stated in the Grant Award Agreement.

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Grantee	A recipient of a Grant funds.
Internal Controls	Internal Controls means a process, implemented by a Grant Awardee, designed to provide reasonable assurance regarding the achievement of objectives in the following categories: 1. Effectiveness and efficiency of operations; 2. Reliability of reporting for internal and external use; and 3. Compliance with applicable laws and regulations.
Notice of Funding Opportunity (NOFO)	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs. The announcement provides eligibility, evaluation criteria, funding priorities, and submission information.
Post-Award	The period of time in-between the date of the Grant Approval Letter and the date of the Grant Close-out Letter.
Progress Report	Document providing information about the project or program's progress in achieving the goals and objectives of the Grant provided by the Grantee. The frequency of submission is set in the Grant Award Agreement.
Scope of Audit	Set of boundaries that define what the Grant Audit will cover. It's a critical step in the audit planning process that helps ensure the audit is efficient, effective, and focused.
Sponsoring Department	CalOptima Health department responsible for informing the design and development of the Grant Program and reviewing Progress Reports and the Final Report to ensure specific Grant Program objectives and outcomes are achieved. The Sponsoring Department will work with Grants Management on the operationalizing and monitoring of the Grant.
Subcontracting	The process where the Grantee delegates a portion of the Grant Award and Grant Budget to an external organization or individual to help complete the project. The Subcontractor retains all the duties and obligations of the Grantee outlined in the Grant Agreement. The Grantee is principally responsible for the oversight, performance and accountability of all Subcontractors.

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For 20261105 BOD Review Only

Policy:	HH.4004
Title:	**Grant Audits/Reviews**
Department:	Office of Compliance
Section:	Internal Audit
CEO Approval:	*/s/*
Effective Date:	01/01/2025
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

The purpose of Grant Audits and Reviews are to provide independent and objective assurance that Grant funds are managed in accordance with applicable laws, regulations, and award requirements through Internal Controls in place to ensure the efficient, effective, and compliant use of funds. These internal reviews and audits promote transparency, accountability, and responsible stewardship of public and grantor resources.

II. POLICY

A. The objective of Grant Audits and Reviews are to provide oversight to reassure CalOptima Health's Board and management to ensure compliance with Grant Award requirements and appropriate use of funds. This includes evaluating whether:

1. Grant expenditures are allowable, allocable, and reasonable under the Grant Award requirements, applicable laws and regulations, and promote effective and reasonable Internal Controls.
2. Funds are used in accordance with the terms and conditions of the Grant Agreement.
3. Internal Controls support accurate and appropriate financial and performance reporting.
4. There is adequate oversight to prevent and detect fraud or waste.
5. Grant Objectives are being achieved in a manner consistent with Grantor expectations and CalOptima Health's policies, procedures, and a Grant Agreement.
6. Grant Management reporting is operating as an effective Internal Control.
7. Conducting special examinations and reviews upon the completion of Board approved Grants, or on an interim basis as needed.
8. Appropriate policies, procedures and industry best practices are present and being followed.
9. The use of Grant funding resources and recommending improvements in policy, procedures, and operations. In addition, the Internal Audit Department will be recommending the best practices and enhancements for Internal Controls that includes desktop procedures for Grant funds.

B. These internal audits are conducted in alignment with the Institute of Internal Auditors (IIA) Global

Internal Audit Standards to provide independent assurance to the Board, management, grantors, and stakeholders responsible for Grant funding. These standards ensure that Grant internal audits are performed with integrity, objectivity, and professional competence. Internal Audit activities follow a risk-based approach and will include sufficient and appropriate procedures to support any conclusions or recommendations provided in Audit Reports.

C. Grants shall be established and administered in accordance with CalOptima Health Policy AA.1400: Grant Management.

D. Post-Award Grant Close-out occurs at the end of the Grant lifecycle at which point the awarding entity, CalOptima Health, determines that the Grantee has completed all applicable administrative actions. Grant Close-out Review is the final stage of the Grant Management process and is performed by the Sponsoring Department. Grant Close-out Review is achieved upon completion of:

1. Completion of all provisions and requirements outlined in the Grant Award Agreement, including all Attachments, Addendums, Extensions, and Modifications.

2. Issuance of a Grant Close-out Letter from the Sponsoring Department to the Grantee.

3. Grant Close-out Review as required by CalOptima Health Policy AA.1400: Grant Management.

E. Internal Audit Opinion Policy for Grant Auditing

1. In accordance with the IIA's Global Internal Audit Standards, internal Audit Reports for Grant-related engagements may include the following opinions or assessments:

a. Formal Opinion: A formal opinion is issued when sufficient, appropriate evidence has been obtained. This opinion will assess the effectiveness of Internal Controls, compliance with Grant requirements, and level of residual risk. Typical opinion descriptors include:

i. Adequate;

ii. Needs Improvement;

iii. Unsatisfactory; and/or

iv. Low / Moderate / High-Risk.

b. Narrative Assessment: If the engagement scope is limited or data is insufficient, the report may present descriptive findings and risks without issuing a formal opinion.

c. No Opinion: If the audit cannot be completed due to scope limitations or lack of evidence, the report will clearly state that no opinion is provided and disclose the reasons for the limitation.

III. PROCEDURE

A. Upon completion of the Grant Close-out Review, a Grant Audit may be performed to validate the attainment of financial and Grant Objectives as documented in the Grant Award Agreement and Grant Close-out Review.

1. Grants with aggregate payments of $50,000 or more shall be audited. Grants under $50,000 with incomplete or non-existent Grant Close-out Review documentation may also be selected for audit.

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2. The Sponsoring Department shall provide a copy of the final Grant Close-out Review to CalOptima Health's Internal Audit department within thirty (30) calendar days of receiving it.

3. The Sponsoring Department shall provide the following documentary evidence to the Internal Audit Department within sixty (60) calendar days of completing the final Grant Close-out Review.

   a. CalOptima Health Board Action Request (COBAR) authorizing Grant or Grant Program.

   b. Internal presentations of the Grant or Grant Program to CalOptima Health's leadership.

   c. Sponsoring Department's Notice of Funding Opportunity (NOFO) document.

   d. Grant Application, including evidence of approval by the Evaluation Committee.

   e. Grant Approval Letter from the Sponsoring Department to the Grantee.

   f. Signed Grant Award Agreement, including all Addendums, Amendments, and Extensions.

   g. Evidence of Grantee's California DOJ Registry Status indicating a "Current" status.

   h. Periodic Progress Reports and Final Report as outlined in the Grant Award Agreement, including evidence of review and approval.

   i. Grant Budget and financial reporting, including supportive evidence such as invoices, etc.

   j. Audited Financial Statements, including Single Audits, if any, for the relevant Grant Term. Financial Statements should include supporting schedules of donor-restricted Net Assets.

   k. IRS Form 990 tax filing throughout the relevant Grant Term.

   l. Copies of all Check Requests and payments from CalOptima Health's Finance Department to the Grantee, including evidence of deposit by the Grantee.

   m. Internal newsletters, photographic material, or management reporting evidencing Grantee's attainment of the Grant Objectives as outlined in the Grant Award Agreement.

   n. Evidence that unspent Grant funds were recouped.

   o. Grant Close-out Letter issued by the Sponsoring Department to Grantee.

   p. The Internal Audit Department may request additional evidence directly from the Grantee.

4. Collection of evidence and supporting documentation needed to complete Grant audit/review:

   a. The Sponsoring Department shall coordinate the collection of all relevant records for the audit, review such records, and provide records to the Internal Audit Department in a timely manner.

   b. The Internal Audit Department may request evidence or other supporting documentation directly from the Grantee.

   c. The Sponsoring Department shall support and assist the Internal Audit Department's efforts to collect responses, evidence and supporting documentation from the Grantee, if necessary.

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5. The Internal Audit Department shall design each Scope of Audit using a risk-based approach to align with the IIA Global Internal Audit Standards to ensure that Grant Objectives were achieved as reported and funds were appropriately used for their intended purpose. The Scope of Audit shall include and assess the following activities:

    a. Audit checklist of required documents and approvals.

    b. Complete and accurate fulfillment of the Grant Management process.

    c. The Grantee's obligations were completed according to the Grant Award Agreement.

    d. Grant expenditures are appropriately tied to the Grant Budget, aligned with the Grant Objectives, and supported by appropriate and legitimate documentation.

    e. Grant funds were wholly used for the Grant's intended purpose without any evidence of fraud, waste or abuse.

    f. Unused Grant funds were wholly refunded to CalOptima Health.

    g. Grant Close-out Review completed with a Final Report to CalOptima Health's leadership.

    h. The Scope of Audit may be as broad or restricted as required to meet the organization's needs.

6. Planning shall commence within thirty (30) days of receiving a complete Grant Close-Out Review package of documentation and information from CalOptima Health Grants Management, the Sponsoring Department, and Grantee. If documentation remains incomplete after sixty (60) days, the Internal Audit Department may initiate a focused Review or request a Corrective Action Plan (CAP) from CalOptima Health Grants Management and/or the Sponsoring Department in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

7. Grant Audit/Review fieldwork will conclude within the following targeted timeframes:

    a. Grant Review: sixty (60) to one hundred and twenty (120) days after initial engagement.

    b. Grant Audit: ninety (90) to one hundred and eighty (180) days after initial engagement.

    c. Timeframes may be adjusted due to delays in receiving audit deliverables, coordination of resources, conflicting workloads, or other unforeseen circumstances.

8. All Expenditures and Subcontracting must be authorized and tied to the purpose of the Grant.

    a. Expenditures are unallowable when they:

        i. Are not included in the approved Grant Budget.

        ii. Lack sufficient evidence or other supporting documentation.

        iii. Fall outside the Objectives of the Grant or Term of the Grant.

        iv. Violate the terms and conditions of the Grant Award Agreement.

    b. Subcontracting is unallowable when:

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i. The Grantee uses a Subcontractor not approved in writing by CalOptima Health.

ii. The activity performed was not permitted under the Grant Award Agreement.

iii. The Grantee failed to disclose the Subcontractor in the Grant Application or subsequent approvals.

c. When potential unallowable Expenditures and/or Subcontracting are identified, the Internal Audit Department shall:

i. Document the issue in the audit working papers with supporting evidence (e.g., invoices, receipts, contracts, financial reports, or any notes to the contrary).

ii. Determine whether the issue is isolated or systemic based on the Scope of Audit defined in Section III.A.5 of this Policy.

iii. Document any observations of unallowable Expenditures and Subcontracting in the Audit Report per Section III.A.8 of this Policy.

iv. Quantify all suspected unallowable Expenditures and Subcontracting in the Audit Report for review and possible recovery by CalOptima Health Grants Management.

v. Report any suspected fraud, waste, or abuse (FWA) to the Office of Compliance in accordance with CalOptima Health Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting.

9. Upon completion of the Grant Audit or Review, the Internal Audit Department shall provide a report to CalOptima Health's Chief Compliance Officer and Grant Management.. The Audit Report shall include the following:

a. Executive Summary;

b. General Information;

c. Participants;

d. Definitions;

e. Scope, Activities, and Methodology;

f. Documents and Evidence Reviewed;

g. Observations;

h. Recommendations; and

i. Conclusions: The Audit Report shall contain an opinion concerning the overall adequacy of controls, operational procedures, and outcomes.

10. The Internal Audit Department will coordinate with and inform management of the results of all audits, the submission of audit responses, and implementation of audit recommendations.

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11. The Internal Auditor Department may report the status of completed audits to the Compliance Committee. The Internal Audit Department will also submit written updates directly to the Committee Chairperson as they are completed throughout the quarter.

12. Observations, Findings, or Conclusions could result in a request for a Corrective Action Plan. Corrective Action Plans shall be administered in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

13. The Chief Compliance Officer may choose to outsource any or all functions of the Grant Audit and appoint the Director of the Internal Audit Department to facilitate all communications and audit work with the engaged external auditor. Supplemental Grant Audits may be contracted to perform independent validation and audit procedures, which would primarily leverage/review the audit work performed by the Internal Audit Department.

14. Objectivity is essential to the Grant Audit process. Internal Audit Department personnel shall avoid actual and apparent conflicts of interest. Internal Audit Department personnel should not be involved in the development and installation of any Grant systems or procedures, preparation of records, or other activities that the Internal Audit staff may review or appraise that could be subject to a Grant Audit. Internal Audit personnel may be consulted on the design or adequacy of controls incorporated into new systems and procedures or on revisions to existing systems.

15. Grant Audits shall be performed with absolute independence and control over the audit work. Friendships, personal or business relations, reputations, outside influence, or other factors must not be allowed to alter the Scope of Audit or outcomes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1400: Grant Management
B. CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
C. CalOptima Health Policy HH.2005: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/06/2025	Regular Meeting of the CalOptima Health Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	HH.4004	Grant Auditing	Administrative
Revised	11/01/2025	HH.4004	Grant Audits/Reviews	Administrative
Revised		HH.4004	Grant Audits/Reviews	Administrative

For 20261105 BOD Review Only

IX. GLOSSARY

Term	Definition
Audit Report	Formal written opinion issued by an independent auditor as an assurance service in order to make decisions based on results and conclusions derived from the audit.
Check Request	A warrant device authorizing payment to a designated beneficiary on demand or after a specific date.
Corrective Action Plan	Step-by-step plan that outlines how to address issues and deficiencies in a program or process. The goal of a CAP is to resolve issues and improve operations and processes.
Evaluation Committee	A Committee of qualified staff and subject matter experts appointed by CalOptima Health's Grants Management department to review and assess Grant Applications and program proposals.
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Grant Approval Letter	Written document informing a Grantee that the Grant Application they submitted has been approved.
Grant Audit/ Review	An independent and comprehensive review of a Grant after close-out to ensure that Grant funds were used in accordance with the Grant Award Agreement's terms and conditions. A Grant Review is generally smaller in scope and seeks to provide a fast track validation of specific activities, achievements, and/or expenditures of the Grant.
Grant Award	The total dollar amount awarded to the Grantee by CalOptima Health through the Grant Management Policy and Procedure.
Grant Award Agreement	Funding agreement between CalOptima Health and the Grantee that sets the terms, conditions, and requirements of a Grant.
Grant Budget	Financial plan that outlines the estimated expenses and income for a project or program that is seeking funding. A Grant budget demonstrates how Grant funds will be used to achieve the project's goals and objectives.
Grant Close-out Letter	A written document that informs the Grantee that all requirements of the Grant have been fulfilled and that the Grant Term has concluded.
Grant Close-out Review	The process by which the awarding entity determines that all required work and administrative actions for a Grant have been completed. It's the final phase of a Grant's lifecycle and marks the end of the awarding entity's relationship with the Grantee.
Grant Management	CalOptima Health's Sponsoring Department's overall exercise of Grant administration throughout the phases of pre-award, award, post-award, and close-out.
Grant Objectives	Statements and milestones that describe the intended outcomes of a Grant-funded project or program.
Grant Program	Funding mechanism to award single or multiple Grants in service to common projects and ideas that support the community as stated in the Notice of Funding Opportunity.
Grant Term	The duration of time in which the Grantee is expected to achieve the Grant's goals and objectives as stated in the Grant Award Agreement.

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Grantee	A recipient of a Grant funds.
Internal Controls	Internal Controls means a process, implemented by a Grant Awardee, designed to provide reasonable assurance regarding the achievement of objectives in the following categories: 1. Effectiveness and efficiency of operations; 2. Reliability of reporting for internal and external use; and 3. Compliance with applicable laws and regulations.
Notice of Funding Opportunity (NOFO)	CalOptima Health's formally issued announcement of the availability of a Board-approved and authorized Grant opportunity through one of its Community Investment programs. The announcement provides eligibility, evaluation criteria, funding priorities, and submission information.
Post-Award	The period of time in-between the date of the Grant Approval Letter and the date of the Grant Close-out Letter.
Progress Report	Document providing information about the project or program's progress in achieving the goals and objectives of the Grant provided by the Grantee. The frequency of submission is set in the Grant Award Agreement.
Scope of Audit	Set of boundaries that define what the Grant Audit will cover. It's a critical step in the audit planning process that helps ensure the audit is efficient, effective, and focused.
Sponsoring Department	CalOptima Health department responsible for informing the design and development of the Grant Program and reviewing Progress Reports and the Final Report to ensure specific Grant Program objectives and outcomes are achieved. The Sponsoring Department will work with Grants Management on the operationalizing and monitoring of the Grant.
Subcontracting	The process where the Grantee delegates a portion of the Grant Award and Grant Budget to an external organization or individual to help complete the project. The Subcontractor retains all the duties and obligations of the Grantee outlined in the Grant Agreement. The Grantee is principally responsible for the oversight, performance and accountability of all Subcontractors.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

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

Recommended Action

Authorize and direct the Chair of the CalOptima Health Board of Directors to execute Amendment 03 to the Primary Contract and Amendment 02 to the Companion Contract for the Program of All-Inclusive Care for the Elderly between the California Department of Health Care Services and CalOptima Health.

Background

Since October 2009, the CalOptima Health Board of Directors (Board) has taken numerous actions related to the CalOptima Health Program of All-Inclusive Care for the Elderly (PACE). On June 6, 2013, the Board authorized the execution of the PACE agreement between Department of Health Care Services (DHCS) and CalOptima Health (the "Primary Contract"), as well as the agreement with the Centers for Medicare & Medicaid Services for the operation of the CalOptima Health PACE site. Beginning in September 2015, the Board authorized execution of various amendments to the Primary Contract for calendar year (CY) payment rates and other provisions, as summarized in the attached Appendix.

In November 2020, DHCS and CalOptima Health entered into a new Primary Contract for PACE, with an effective date of January 1, 2021, that replaced the then existing contract. The Primary Contract specifies, among other terms and conditions, the capitation payment rates CalOptima Health receives from DHCS to provide PACE participants with health care services. The current Primary Contract expires on December 31, 2026.

On September 7, 2023, the Board authorized CalOptima Health to enter into a new agreement, referred to as the Companion Contract, with an effective date of January 1, 2023. The need for the separate Companion Contract stemmed from the eligibility criteria changes in the Medi-Cal program for the Older Adult Expansion (*i.e.,* 50 years old and above regardless of immigration status). The Companion Contract provides for PACE coverage of those members who are considered Unsatisfactory Immigration Status but State Funded (UIS State-Only). Under the Companion Contract, DHCS provides PACE

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coverage for UIS State-Only members without the federal funds match in capitation. The current Companion Contract expires on December 31, 2026.

Discussion

Primary Contract

On September 15, 2026, DHCS provided CalOptima Health with a draft Amendment 03 to the Primary Contract. Amendment 03 revises the Primary Contract for PACE as follows:

- Increases the State budget funds (maximum amount payable).
- Extends the term of the current contract through December 31, 2027.
- Updates Exhibit B, Budget Detail and Payment Provisions, to include capitation rates for CY 2026.
- Updates Exhibit G, the DHCS Business Associate Addendum (BAA) to DHCS's July 2026 template. CalOptima Health staff is requesting changes to the DHCS BAA prior to agreeing to sign it as part of this Amendment 03.

All other terms and conditions shall remain the same.

Companion Contract

On September 15, 2026, DHCS provided CalOptima Health with a draft Amendment 02 to the Companion Contract for signatures. Amendment 02 revises the Companion Contract for PACE as follows:

- Increases the State budget funds (maximum amount payable).
- Extends the term of the current contract through December 31, 2027, with the DHCS capitation rates for the UIS State-Only population renewed on a CY basis.
- Updates Exhibit B, Budget Detail and Payment Provisions, to include capitation rates for CY 2026.
- Updates Exhibit G, the DHCS BAA to DHCS's July 2026 template. CalOptima Health staff is requesting changes to the DHCS BAA prior to agreeing to sign it as part of this Amendment 02.

All other terms and conditions shall remain the same.

If needed, CalOptima Health staff will return to the Board for any further updates to the Primary Contract and/or the Companion Contract that are materially different from the current versions.

Fiscal Impact

The CY 2026 PACE rates have been incorporated in CalOptima Health's Fiscal Year (FY) 2025-26 financials. Staff included updated rates for the period of July 1, 2026, through December 31, 2026, in the CalOptima Health FY 2026-27 Operating Budget.

Rationale for Recommendation

CalOptima Health's execution of the Amendment 03 to the Primary Contract and Amendment 02 to the Companion Contract are necessary for the continued operation of CalOptima Health PACE.

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Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Appendix 1: Summary of Amendments to PACE Primary Contract

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APPENDIX TO AGENDA ITEM 14

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

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend* contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance. *On 9/20/17, DHCS informed CalOptima this would be moved to be captured in A04.	August 3, 2017
A04 provided an extension of the contract termination date to December 31, 2018 and incorporated ADA compliance language.	December 7, 2017
Future Amendment (A05) provided draft capitation rates for CY 2017 for the period of January 1, 2017 through December 31, 2017, developed by the "Amount That Would Have Otherwise Been Paid (AWOP)", and apply the Managed Care Organization (MCO) Tax for the period January 1, 2017 through June 30, 2017.	December 7, 2017

Amendments to Primary Agreement with DHCS	Board Approval
A06 provided an extension of the contract termination date to December 31, 2019.	November 1, 2018
A07 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2018 for the period of January 1, 2018 through December 31, 2018 and applies the Managed Care Organization (MCO) Tax for this period. First time rates for PACE developed using the Rate Development Template (RDT)/experience-based rate methodology. Incorporates additional language updates for various contract provisions, including restrictions on delegation as well as emergency preparedness.	April 4, 2019
A08 provided revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2019 for the period of January 1, 2019 through December 31, 2019 and applies the Managed Care Organization (MCO) Tax for this period. Incorporates additional language updates for other contract provisions, including Nursing Facility Services payment rates.	September 5, 2019
A09 provided an extension of the contract termination date to June 30, 2020.	December 5, 2019
A10 provided an extension of the contract termination date to December 31, 2020 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2020 for the period of January 1, 2020 through December 31, 2020.	June 4, 2020
New Primary Agreement: Replaces the previous contract and subsequent amendments in their entirety, effective January 1, 2021. Also extends the contract termination date to December 31, 2024, with DHCS capitation rates renewed on a calendar year basis. The new agreement aligns the PACE DHCS agreement with: • provisions contained in the Managed Care Plan (MCP) Medi-Cal contracts; and • provisions in the CMS 2019 Final Rule.	November 5, 2020
A01 provided an extension of the contract termination date to December 31, 2025 and also provides revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2022 for the period of January 1, 2022 through December 31, 2022 Incorporates Aid Code 38 as an eligible Aid Code for PACE and modifies numbering for provisions throughout the Exhibits, to correct contract cross-references or correct regulatory citations.	November 3, 2022
A02 provides 1) increase to the maximum allowed encumbrance amount, 2) extension of the contract termination date to December 31, 2026 and 3) adjustments to CY 2022 rates and also implements capitation rates for the *Full-Dual* population and *Non-Dual eligible* population for CY 2023, CY 2024, and CY 2025 for the period of January 1, 2023 through December 31, 2026 and 4) include provision for Executive Order N-6-22 on Russia Sanctions.	August 7, 2025

Amendments to Primary Agreement with DHCS	Board Approval
A03 provides 1) increase to the maximum allowed encumbrance amount, 2) extension of the contract termination date to December 31, 2027, 3) implements capitation rates for CY 2026 for the period commencing January 1, 2026, and 4) updates DHCS' Business Associate Addendum (BAA) ~~to the April 2024 version~~.	**Pending**

Amendments to Primary Agreement with CMS	Board Approval
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016
A02 CalOptima PACE initiated a waiver to allow Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in CalOptima PACE, which was approved by CMS on March 12, 2018 and amended *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	September 7, 2017

The following is a summary of amendments to the PACE "Companion Contract" Agreement approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to "Companion Contract" Agreement with DHCS	Board Approval
Initial effective 1/1/23 provides coverage for Unsatisfactory Immigration Status (UIS) population.	September 7, 2023
A01 provides 1) increase to the maximum allowed encumbrance amount, 2) extension of the contract termination date to December 31, 2026, and 3) revised capitation rates for CY 2023, CY 2024, and CY 2025 for the period of January 1, 2023 through December 31, 2026.	August 7, 2025
A02 provides 1) increase to the maximum allowed encumbrance amount, 2) extension of the contract termination date to December 31, 2027, 3) adds a "*Prompt Payment Clause*", 3) implements capitation rates for CY 2026 for the period commencing January 1, 2026, and 4) updates DHCS' Business Associate Addendum (BAA) ~~to the April 2024 version~~.	**Pending**

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

15. Approve New Long Term Services and Support Policy CC.2200

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Action

Approve a new CalOptima Health Policy CC.2200: CalOptima Health Hospice Coverage, Notification and Validation Requirements to reflect clinical operational requirements for CalOptima Health's Covered California product, effective January 1, 2027.

Background

Over the past two years, CalOptima Health has prepared to participate in the Covered California program, undertaking steps such as convening a stakeholder steering committee and securing necessary approvals at both the county and state levels. This included obtaining authorization from the Orange County Board of Supervisors (BOS) and receiving regulatory approval from the Department of Managed Health Care (DMHC) to offer a Covered California product under the Knox-Keene Act. Staff has developed this hospice policy to ensure compliance with and provide support for CalOptima Health's Covered California product.

Discussion

This policy outlines CalOptima Health's requirements for providing, authorizing, and paying for hospice care services for Covered California members who are certified as terminally ill, typically with a life expectancy of six months or less. The policy includes the following:

- Eligibility requires physician certification and voluntary election by the member or their authorized representative, with coverage continuing as long as the member remains eligible and/or obtains recertification.
- Hospice services include four levels of care: routine home care, continuous home care, inpatient respite care, and general inpatient care.
- Providers must submit timely notices, supporting documentation, and obtain prior authorization, with proper documentation being essential for payment. Members may revoke or transfer care during each benefit period, and care coordination responsibilities are divided between hospice providers and CalOptima Health for related and unrelated services.

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- Reimbursement follows Medicare rates, and providers must meet various certification and clinical requirements.

The policy emphasizes program integrity, fraud prevention, and seamless care coordination with providers and health networks.

Policy & Procedure Summary – Long Term Services and Support

Policy	***Summary***
CalOptima Health Policy CC.2200: CalOptima Health Hospice Coverage, Notification and Validation Requirements	Created a Covered California line of business policy to clarify CalOptima Health's hospice benefit coverage, notification, and validation requirements.

Staff seek the CalOptima Health's Board of Directors' approval of the attached policy. The policy would be effective January 1, 2027.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what is incorporated in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

Approval of the new policy and procedure related to clinical operations will support CalOptima Health's operational implementation of the Covered California product.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. CalOptima Health Policy CC.2200: Hospice Coverage, Notification and Validation Requirements (New)

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Policy:	CC.2200
Title:	**CalOptima Health Hospice Coverage, Notification and Validation Requirements**
Department:	Long Term Services and Supports
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2027
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

To clarify CalOptima Health's hospice benefit coverage, Notification and Validation requirements.

II. POLICY

A. CalOptima Health and its Health Networks shall be responsible for ensuring the provision of Hospice Care services for Terminally Ill Members who meet the requirements outlined in Section II.B. of this policy.

B. Requirements for the initiation of outpatient Hospice Care services include:

1. The attending physician and/or the hospice medical director certifies the Member's Terminal Illness (life expectancy up to twelve (12) months;

   a. Guidance for determining Terminally Ill status provided by the Centers for Medicare & Medicaid Services (CMS) is not wholly restrictive and/or inclusive for CalOptima Health Members to receive Hospice Care services.

   b. The guidelines are a tool and are not exclusive to determining eligibility for Hospice Care and do not replace a physician's professional judgment, as some Members may not meet these guidelines, yet still have a life expectancy of six (6) months or less.

2. The Member or Authorized Representative understands and accepts Hospice Care in lieu of curative care for the Terminal Illness;

3. Election of Hospice Care occurs when the Member or Authorized Representative voluntarily files an election statement with the Hospice Provider;

   a. CalOptima Health will facilitate Member election of Hospice Care services by engaging in practices that avoid unnecessary delays and complications.

   b. CalOptima Health will validate Member elections to prevent Fraud, Waste, and Abuse.

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4. A Member younger than twenty-one (21) years of age and certified by a physician as having a life expectancy of six (6) months or less, may elect to concurrently receive Hospice Care services and Palliative Care in addition to curative treatment of the hospice-related diagnosis in accordance with CalOptima Health Policy GG.1550: Palliative Care Services; and

5. CalOptima Health will not deny Hospice Care to Members certified as Terminally Ill.

C. CalOptima Health is required to provide Hospice Care services upon Member election to start and receive such care. There is no fixed limit on hospice duration – coverage continues as long as the Member meets the hospice criteria, subject to period physician recertification.

D. Revocation of Hospice:

1. A Member's voluntary election of hospice may be revoked or modified at any time during the benefit period.

2. To revoke the election of Hospice Care, the Member or Authorized Representative must file a signed statement with the Hospice Provider revoking the individual election for the remainder of that benefit period, including the effective date of the revocation.

3. The Hospice Provider must submit the Member's signed hospice revocation statement to CalOptima Health within five (5) calendar days.

4. The revocation effective date may not be retroactive.

5. At any time after revocation, or discharge by the hospice for cause, a Member may execute a new election, if they meet hospice coverage eligibility requirements.

6. If the Member re-elects Hospice Care, the Hospice Provider must submit a new hospice election form to CalOptima Health.

7. The Member or Authorized Representative may change the designation of a Hospice Provider once in each benefit period from the original Hospice Provider with which the election was made. This change of the designated Hospice Provider is not a revocation of the hospice benefit.

F. Members may elect Hospice Care in lieu of curative treatment for their Terminal Illness. Members who elect Hospice Care are still entitled to curative treatment for conditions unrelated to their Terminal Illness.

G. Services for children with life-threatening conditions

1. In addition to Hospice Care services, children and families may benefit from receiving Palliative Care services. Children are eligible for Hospice Care and may elect to receive concurrent curative treatment of the hospice related diagnosis and concurrent Palliative Care.

2. Palliative Care services provided in accordance with CalOptima Health Policy GG.1550: Palliative Care Services.

3. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition.

H. Four (4) Levels of Care (LOC):

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1. Routine Home Care;

2. Continuous Home Care;

3. Inpatient Respite Care; and

4. General Inpatient Care.

I. Notification and Validation Requirements

1. For Covered California Members, the Hospice Provider shall notify and coordinate with CalOptima Health or the Member's assigned Health Network for Covered Services that are unrelated to the Terminal Illness.

2. Covered California Members may access Hospice Care within twenty-four (24) hours of Notification of hospice request.

3. Prior authorization is required for Hospice Care services in accordance with CalOptima Health Policy CC.1600: Authorization and Processing of Referrals. A Hospice Provider shall provide documentation to support these LOCs, including the appropriate election form within five (5) calendar days of certification and election of Hospice Care.

4. CalOptima Health may deny payment and/or Hospice Care services if it is determined, based on documentation, that the Hospice Care services are not Medically Necessary or the Member is not Terminally Ill. In such cases, liability is placed on the Hospice Provider.

5. For Covered California Members requiring General Inpatient Care, planned or unplanned admissions, a Hospice Provider, in-network and out-of-network providers, shall notify CalOptima Health of placements that occur after normal business hours on the next business day. Hospice Providers shall submit an authorization request for Hospice Care services within the next business day or no later than seven (7) calendar days after the start of Hospice Care services. If a Hospice Provider does not provide adequate clinical documentation or documents to substantiate the need for General Inpatient Care, the CalOptima Health or Health Network medical director may reduce the LOC to Routine Home Care. Following such a decision, the Hospice Provider shall have the right to appeal the LOC decision, in accordance with CalOptima Health Policies CC.1200: Member Appeals.

6. Per Medicare policy, General Inpatient Care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be appropriately provided in other settings. Skilled nursing care may be needed by a Member whose home support has broken down, making it no longer appropriate to furnish needed care in the home setting. General Inpatient Care under the hospice benefit is not equivalent to a hospital LOC under the Medicare benefit.

7. CalOptima Health may require documentation of medical justification for Continuous Home Care and/or Inpatient Respite Care following the provision of General Inpatient Care and Continuous Home Care.

    a. If the documentation does not support the Continuous Home Care or Inpatient Respite Care LOCs, or if the documentation is inadequate, reimbursement may be reduced to the rate for Routine Home Care.

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b. The Hospice Provider may submit an appeal for reconsideration of payment by including additional documentation of the Medical Necessity for the increased LOC.

8. The Hospice Provider shall submit a Notification for Hospice Care services for a CalOptima Health Member within five (5) calendar days after the start of Hospice Care services for the following to include the dates of service along with documentation of services provided:

a. Continuous Home Care;

b. Routine Home Care;

c. Inpatient Respite Care; and

d. Special Physician Services.

J. Member requests to change a Hospice Provider, the current Hospice Provider shall provide a transferring Member with a transfer summary signed by the Member's hospice attending physician. The transfer summary shall include, but not be limited to the following information:

1. Member's diagnosis;

2. Pain treatment, and management;

3. Medications;

4. Medical treatments;

5. Dietary requirement;

6. Known allergies;

7. Treatment plan; and

8. Previous hospice benefit period information.

K. CalOptima Health and its Health Networks, in accordance with the Health Network-specific DOFR, are responsible for the provision of all Medically Necessary Covered Services not related to a Member's Terminal Illness, including Covered Services provided by a Member's Primary Care Provider (PCP).

L. CalOptima Health or its Health Network, in accordance with the active DOFR, may provide ongoing care coordination to Members receiving Hospice Care to ensure that services necessary to diagnose, treat, and follow-up on conditions not related to the Terminal Illness continue to be provided, or are initiated, as necessary.

M. CalOptima Health shall ensure for any authorizations for which it is responsible, for Hospice Care services, are consistently applied to medical/surgical, mental health, and substance use disorder services.

N. CalOptima Health will contract with Hospice Providers or establish a Letter of Agreement, as appropriate with out-of-network providers, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

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1. Prior to claims, CalOptima Health will ensure out-of-network providers have the following:

    a. Medicare certification;

    b. Licensed by the California Department of Public Health (CDPH); and

    c. Has a National Provider Identification number.

2. CalOptima Health shall restrict coverage to in-network providers, unless Medically Necessary services are not available in-Network.

O. CalOptima Health shall ensure Continuity of Care for Members receiving Hospice Care, in accordance with CalOptima Health Policies CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services.

P. CalOptima Health will instruct staff, subcontractors, downstream subcontractors, network providers, other programs, and out-of-network providers of the importance of timely recognition of a Member's eligibility for Hospice Care services and their election of Hospice Care services.

1. Once a Member elects Hospice Care, CalOptima Health Network providers and case management staff will work closely with Hospice Providers to facilitate the transfer of services for the Member from those directed toward cure and/or prolongation of life, to those directed toward palliation.

2. Ongoing care coordination will be provided to ensure that services necessary to diagnose, treat, and follow-up on conditions unrelated to the Terminal Illness continue to be provided, or are initiated as necessary, in accordance with CalOptima Health Policy CC.1600: Authorization and Processing of Referrals.

Q. Services not provided by Hospice Provider:

1. Private pay room and board or residential care.

2. Acute in-patient hospitalization unrelated to the Terminal Illness.

3. Level A or Level B Nursing Facility for unrelated issues.

4. Physician and/or consulting Physician Services not related to the Terminal Illness or Physician Services where the physician is not an employee of hospice or providing services under an arrangement with hospice.

5. Other necessary services for conditions unrelated to the Terminal Illness.

R. CalOptima Health will remain proactive and vigilant regarding program integrity, especially those that address Fraud, Waste and Abuse, as outlined in CalOptima Health's contract.

1. CalOptima Health will review documentation received from the Hospice Provider to determine the qualification of the Member to receive hospice, and if appropriate, CalOptima Health will request additional documentation for such a determination, to confirm the proper and appropriate claim payments and service authorizations are made and not based on fraudulent submissions.

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S. CalOptima Health will apply appropriate compliance review protocols and procedures regarding claim processing and utilization management systems upon receipt of a hospice election form and/or hospice claim to identify a Member as receiving hospice, including notifying Member's PCP of the Member's election to hospice and adding other system indicators to flag Members receiving Hospice Care services.

T. CalOptima Health will ensure there is no duplication of the Medicare hospice benefit:

1. If a Covered California Member is or becomes eligible for Medicare and elects Medicare's hospice benefit, CalOptima Health shall not cover duplicative Hospice Care services during the Medicare hospice period.

2. The Member may remain enrolled in CalOptima Health for other non-hospice medical benefits.

3. After the Medicare hospice election ends, CalOptima Health will resume coverage of Medically Necessary services, including (if needed) hospice.

III. PROCEDURE

A. CalOptima Health or its Health Networks, in accordance with the Health Network-specific DOFR, shall be responsible for providing Hospice Care to a Covered California Member if the following criteria are validated:

1. The physician has executed a certification of Terminal Illness that complies with 42 CFR § 418.22.

2. The Notice of Election (NOE) is signed by the Member or Member's Authorized Representative. The following must be included on the form:

a. Identification of the Hospice Provider;

b. The Member's or the Member's Authorized Representative's acknowledgement that he or she has full understanding that the Hospice Care services given as related to the Member's Terminal Illness will be palliative, rather than curative in nature, unless the Member is a child under twenty-one (21) years of age, and that certain specified benefits are waived by the election;

c. The effective date of election; and

d. The Member's designated attending physician (if any). Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician, Nurse Practitioner (NP), or Physician Assistant (PA) was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician.

e. The Member's acknowledgment that the designated attending physician was the Member's or Authorized Representative's choice.

f. Information on Member cost-sharing for Hospice Care services;

g. Notification of the Member's or Authorized Representative's right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has

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determined to be unrelated to the Member's Terminal Illness and related conditions and would not be covered by the hospice;

h. Information on the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including the right to immediate advocacy and BFCC-QIO contact information.

i. The signature of the Member or the Member's Authorized Representative.

j. CalOptima Health will require an addendum statement if the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the Member (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the election statement. The addendum statement must include the following:

   i. The addendum must be titles "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."

   ii. Name of hospice.

   iii. Member's name and hospice record identifier.

   iv. Identification of the Member's terminal illness and related conditions.

   v. A list of the Member's conditions present on hospice admission (or upon plan of care update) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions.

   vi. A written clinical explanation, in language the Member (or representative) can understand, as to why the identified condition, items, services, and drugs are considered unrelated to the Member's terminal illness and related conditions and not needed for pain or symptom management.

   vii. References to any relevant clinical practice, policy, or coverage guidelines.

   viii. Information on the following:

      a) Purpose of addendum

      b) Right to immediate advocacy

      c) Name and signature of the Member (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgment of receipt of the addendum (or its update) and not the Member's (or representative's) agreement with the hospice's determinations.

   ix. Date the hospice furnished the addendum.

k. All Hospice Providers must complete the appropriate hospice NOE and addendum and submit them within five (5) calendar days to CalOptima Health or health network.

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B. A Hospice Provider shall be responsible for services related to the Member's Terminal Illness, including, but not limited to, pharmacy, physician, social services, nursing, home health aide services, home maker services, Durable Medical Equipment (DME), supplies, multi-disciplinary Hospice Care services, hospice physician consultation for patients, dietary or nutritional counseling, bereavement, grief, and spiritual counseling.

C. Payments for Hospice Care services are based upon the LOC provided. The Medicare hospice rates for hospices' four (4) LOCs are calculated based on the annual Hospice Care rates established under Medicare, and these rates are authorized by federal law, which also provides for an annual increase in payment rates for Hospice Care service. CalOptima Health must update their rates annually to coincide with changes to Medicare rates.

D. Reimbursement will follow the LOC table below in accordance with rates established under Medicare and authorized by federal law. CalOptima Health may pay more, but not less than, the Medicare rate for Hospice Care services. The federal rates for Hospice Care for each fiscal year are printed in the Federal Register.

Level of Care	**Revenue Code**
Routine Home Care	0651
Continuous Home Care	0652
Inpatient Respite Care	0655
General Inpatient Care	0656
Physician Services	0657

E. CalOptima Health will pay inpatient rates (general or respite) for the date of admission and all subsequent inpatient days, except the day on which the Member is discharged. For the day of discharge CalOptima Health will pay the appropriate home care rate, unless the Member dies as an inpatient. If the Member dies as an inpatient, CalOptima Health will pay the inpatient rate for day of discharge.

F. The Hospice Provider must use Revenue Code 0657 when billing for pain and symptom management related to a Member's Terminally Ill condition and provided by a physician employed by, or under arrangements may by, the Hospice Provider. CalOptima Health will reimburse Revenue Code 0657, which is limited to one (1)-visit-per-day, per Member.

G. CalOptima Health may approve short-term hospital or facility care for acute pain or management of acute and severe problems. A Hospice Provider must submit the following documents:

1. A written prescription signed by the Member's attending physician;

2. Member's signed election form;

3. Initial written Plan of Care;

   a. Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group(s) to plan, provide, and/or supervise the care and services offered by the Hospice Provider.

   b. A written Plan of Care must be established by the Member's attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care.

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c. The attending physician, medical director or physician designee, and interdisciplinary group of the hospice must review the Plan of Care and update it at intervals specified in the Plan of Care.

d. CalOptima Health will ensure coordination of care with Hospice Care Providers and allow for the hospice interdisciplinary team to professionally manage the care of the Member.

4. Certification of Terminal Illness;

5. Clinical documentation that justifies General Inpatient Care LOC; and

6. Medication administration records or flow charts that document that services medically required for the General Inpatient Care.

H. Covered California Members may be admitted for General Inpatient Care for any one (1) or more of the reasons specified below:

1. Pain control

a. Required frequent evaluation by a physician/registered nurse;

b. Need more aggressive treatment to control pain than can be attained in a home setting; or

c. Frequent adjustment of medications.

2. Management of symptoms such as:

a. Sudden acute general deterioration requiring intensive nursing intervention;

b. Protracted nausea and vomiting;

c. Respiratory distress which becomes unmanageable, requiring administration of continuous oxygen;

d. Major pathological fracture;

e. Open lesions not responsive to home care and in need of frequent skilled care;

f. Rapid decline or debilitating cachexia inconsistent with home care management; and

g. Psychological and social problems such as, but not limited to:

i. Acute anxiety or depression not responding to milieu therapy;

ii. Collapse of family support resulting from the disease process which requires intensive skilled care in other than the home environment; and

iii. Psychosis or severe confusion secondary to the underlying organic disease.

I. Hospice Notification and Validation for CalOptima Health Members

1. A Hospice Provider shall submit Notification of Hospice election immediately and no later than five (5) calendar days of certification and election of Hospice Care.

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a. In instances where the Hospice Provider does not timely submit the election form to CalOptima Health or Health Network, CalOptima Health or Health Network is not obligated to cover and pay for the days of Hospice Care from the hospice admission date to the date the election form is submitted and accepted by CalOptima Health or Health Network.

b. These non-covered days are the Hospice Providers liability, and the Hospice Provider cannot bill the Member for them.

c. CalOptima Health may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of its claims processing and utilization management functions regarding a Member's certification and election, including supporting documentation.

d. If medical justification is not included or is inadequate for Continuous Home Care or General Inpatient Care, a CalOptima Health medical director may modify the request to a lower LOC pursuant to CalOptima Health Policy CC.1600: Authorization and Processing of Referrals. A Hospice Provider shall have the right to appeal the LOC decision, in accordance with CalOptima Health Policy CC.1200: Appeals.

1. The Hospice Provider shall submit Notification of continued service to CalOptima Health, or its Health Network prior to the expiration of the current election period and shall include:

a. Recertification of Terminal Illness: For the third benefit period re-certification, and every re-certification thereafter, there must be a face-to-face encounter between the Member and the hospice physician or nurse practitioner (NP) no more than thirty (30) days prior to the certification date, to gather clinical findings to determine continued eligibility for Hospice Care.

b. When a Hospice Provider newly admits (i.e. transfer/admission) a Member in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. Under documented exceptional circumstances, a face-to-face encounter within two (2) calendar days after admission will be considered timely.

3. Attestation requirements:

a. Face-to-face encounter with Member is required to determine eligibility and must be performed by hospice physician or hospice NP employed by the Hospice Provider;

b. Physician signature and date must be separate and a distinct section of, or an addendum to, the recertification form and must be clearly titled; and

c. Attestation performed by a NP:

i. Must state clinical findings of visit was provided to the certifying physician; and

ii. Determine life expectancy of six (6) months or less, should the Terminal Illness run its normal course.

4. Timeframe requirements when a Member transfers from one Hospice Provider to another Hospice Provider:

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a. A receiving Hospice Provider may not know if a face-to-face recertification is necessary, as such, the receiving Hospice Provider shall document in the Member's medical record all efforts to obtain the previous hospice benefit period certification of Terminal Illness, either from the transferring Hospice Provider or from other sources; and

b. If the receiving Hospice Provider cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving Hospice Provider completes the intake process. This information must be maintained in the Member's medical record for auditing purposes.

5. Timeframe for exceptional circumstance:

a. Face-to-face encounter is not obtained due to the Member is in the third or later benefit period; or

b. Emergency weekend admission; or

c. CMS Data System and/or Provider Electronic Health Record are not available; the Hospice Provider may be unaware that the Member is in the third or later benefit period. In such documented cases, a face-to-face encounter that occurs within two (2) calendar days after admission will be considered timely; or

d. Member expires within two (2) calendar days of admission without a face-to-face encounter.

6. Medically Necessary Covered Services for conditions not related to a Member's Terminal Illness that are provided to a Member receiving Hospice Care services shall require the same prior authorizations as required for a Member not receiving Hospice Care services.

8. Pharmacy

a. Medications related to the Member's Terminal Illness including, but not limited to: hydration, pain, and nausea control, whether administered orally, by injection or intravenous (IV), shall be included in the per diem Hospice Care rate. These medications shall be obtained through the hospice program and not the CalOptima Health pharmacy system.

b. Medications required for medical conditions not related to Member's Terminal Illness, such as insulin for a diabetic, shall continue to be covered under the CalOptima Health pharmacy program and shall be processed through the CalOptima Health pharmacy system, or by the Health Network for those drugs covered under the Health Network's responsibility.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with Covered California
B. CalOptima Health Policy CC.1200: Member Appeal Process
C. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health Services
D. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals

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E. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
F. CalOptima Health Policy GG.1550: Palliative Care Services
G. Department of Managed Health Care (DMHC) Knox Keene Health Care Service Plan Act and Regulations (2026 Edition)
H. Health and Safety Code (HSC), §§ 1339.31(b) and 1368.2
I. Medicare Benefit Policy Manual, Chapter 9, §§ 20.2 and 20.3
J. Medicare Claims Processing Manual, CR 9201, Chapter 11, §§ 20.1
K. Social Security Act (SSA), §§ 1905(o)(1), 1812(d)(1) and 2110(a)(23)
L. Title 28, California Code of Regulations (CCR), § 1300.68.2
M. Title 42, Code of Federal Regulations (CFR), § 418 *et seq*.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027		CalOptima Health Authorization Requirements for the Provision of Hospice Service	Covered California

For 20261005 Board Review Only

IX. GLOSSARY

Term	Definition
Abuse	Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.
Authorized Representative	An individual who is (1) the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member resides may allow; (*e.g.*, court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity), or (2) appointed in writing by a competent Member to act on behalf of the Member for a limited purpose (*e.g.*, to represent the Member in DMHC Independent Medical Reviews, filing Grievances and Appeals, claims adjudications). The DMHC Authorized Assistant Form may be used to appoint an authorized assistant to assist the Member with Independent Medical Review or complaint, provided a power of attorney for health care decisions or other legal document is submitted by an individual seeking to represent a Member who does not have legal capacity to appoint an authorized assistant.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has a pre-existing provider relationship.
Continuous Home Care	Hospice Care provided in the Member's residence, which consists predominately of skilled nursing care, for a minimum of eight (8) hours in a twenty-four (24)-hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the Member's care.
Covered Services	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.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Durable Medical Equipment (DME)	Medically Necessary medical equipment, as defined by Title 22, California Code of Regulations (CCR) § 51160, that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home.
Fraud	Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code § 3294(c)(3), CA Penal Code §§ 470-483.5). Prevention and early

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Term	Definition
	detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered. Fraud includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit, in accordance with HSC § 1348.
General Inpatient Care	Services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management.
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
Hospice Care	A comprehensive, team-oriented program of comfort care (Palliative Care) for individuals who are Terminally Ill. The focus shifts from curing an illness to managing pain and symptoms, addressing the physical, emotional, social, and spiritual needs of patients and their families.
Hospice Provider	A public agency or private organization, or a subdivision thereof, or a facility which: 1. Is primarily engaged in providing the items and services described in 22 CCR § 51180 to Terminally Ill Members; 2. Make such services available as needed on a 24-hour basis, and 3. Provides bereavement counseling for the immediate family and significant others.
Level of Care (LOC)	Criteria for determining admission to an LTC facility contained in 22 CCR §§ 51334 and 51335 and applicable CalOptima Health policies.
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For Medically Necessary treatment of a mental health or substance use disorder, Medical Necessity shall include a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) in accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care provider, as required by HSC § 1374.72(a)(3)(A).
Member	An individual enrolled in a CalOptima Health program.
Notice of Election (NOE)	A formal document that a hospice provider submits to CalOptima Health to officially open a Member's hospice benefit period. It shows that the Member has chosen the hospice benefit instead of standard medical care for his/her terminal

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Term	Definition
	illness. The NOE must be submitted to CalOptima Health within five (5) calendar days of the start date listed on the Member's election statement.
Notification	For purposes of this policy, direct communication to CalOptima Health or Health Network for Hospice Care services notification for Routine Home Care, Continuous Home Care, and Inpatient Respite Care within thirty (30) calendar days of start of services for CalOptima Health Members.
Palliative Care	As defined in HSC § 1339.31(b), interventions that focus primarily on reduction or abatement of pain and other disease-related symptoms, rather than interventions aimed at investigation and/or interventions for the purpose of cure or prolongation of life.
Physician Services	For purposes of this policy, general supervisory services of the hospice medical director; participation in the establishment of plans of care, supervision of care and services, periodic review and updating of Plans of Care, and establishment of governing policies by the physician of the hospice interdisciplinary team. Physician services not described above must be billed to CalOptima Health separately and include services of the Member's attending or consulting physicians if they are not an employee of the hospice or providing services under arrangements with the hospice. Physician visits by a hospice-employed physician, medical director, or consultant are billable separately.
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the Member's medical records according to 42 CFR § 456.80.
Inpatient Respite Care	Hospice Care provided short-term inpatient care in an acute hospital, skilled nursing facility/Level B, intermediate care facility/Level A, or a hospice facility which is organized to provide inpatient care directly, when necessary to relieve family Members or others primarily caring for the Member.
Routine Home Care	Hospice Care provided in the Member's residence which is not Continuous Home Care.
Special Physician Services	For purposes of this policy, services to manage symptoms that cannot be remedied by the Member's hospice attending physician because of one of the following: 1. Immediate need; and 2. Hospice attending physician does not have the required special skills. Revenue Code 0657 should be billed on a separate line for each date of service and is limited to once per day, per Member, per Hospice Provider.
Terminally Ill or Terminal Illness	A medical prognosis certified by a physician is that a Member's life expectancy is six (6) months or less if the Terminal Illness runs its normal course, as specified by 42 CFR § 418.3 and HSC § 1368.2.
Validation	For purposes of this policy, documentation to support medical justification for services requested for CalOptima Health Members.
Waste	Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

16. Approve CalOptima Health Finance Policies

Contact

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

Recommended Action

1. Approve revisions to the following existing CalOptima Health Finance Policies, effective January 1, 2027:
   a. CalOptima Health Policy FF.1006: Financial Risk Arrangements;
   b. CalOptima Health Policy FF.1010: Shared Risk Pool; and
   c. CalOptima Health Policy MA.3003: Medicare Shared Risk Pool.

2. Approve new CalOptima Health Policy FF.4003: Vendor Exclusion and Preclusion Monitoring, effective November 5, 2026.

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

Staff recommends approval of (i) revisions to three (3) existing finance policies and (ii) one (1) new finance policy. The proposed changes to existing Shared Risk Pool-related policies FF.1006, FF.1010, and MA.3003 strengthen regulatory compliance and support Medical Loss Ratio (MLR) reporting requirements. The new Policy FF.4003 enhances oversight of vendor eligibility to participate in state and federal health care programs.

The following information outlines substantive policy changes that are reflected in the attached redline policies. It does not include non-substantive changes that may also be reflected in the redline (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, or grammatical changes).

Recommended Action 1: Revised Policies

CalOptima Health Policies FF.1006: Financial Risk Arrangements, FF.1010: Shared Risk Pool, and MA.3003: Medicare Shared Risk Pool outline the process for the administration of the Shared Risk Pool (SRP) with a Shared Risk Group (SRG). To comply with the Centers for Medicare & Medicaid Services' final rule provision and recommendations from the California Department of Health Care Services, staff incorporated applicable quality measures into the SRP program. Staff will update SRG

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contracts concurrently and seek CalOptima Health Board of Directors authority to amend the Medi-Cal SRG contracts to reflect the proposed policy changes through a separate action.

FF.1006: Financial Risk Arrangements

Section	Proposed Change	Rationale
Section II.B.2; III.A.7	Adds language that a Physician Hospital Consortium will ensure distributions from risk pool arrangements are tied to measurable quality outcomes and have a defined performance period related to specific health network MLR reporting.	Shared risk settlement payments must be tied to specific, measurable quality outcomes to qualify as medical expenses in MLR reporting.

FF.1010: Shared Risk Pool

Section	Proposed Change	Rationale
Section II.H.3; II.I.3; III.B.2.c; III.C.1.f	Adds language to require an SRG to meet a performance measure in the Pay-for-Value program to receive SRP payments.	Shared risk settlement payments must be tied to specific, measurable quality outcomes to qualify as medical expenses in MLR reporting.
Section II.P	Adds language allowing adjustments to a shared risk settlement for a closed period.	Allows for adjustments to closed shared risk years due to federal or state adjustments.
Section IV and V	Retires Attachment and moves it to the References section.	Allows policy update flexibility while ensuring documents remain referenced for audit and legal purposes.

MA.3003: Medicare Shared Risk Pool

Section	Proposed Change	Rationale
Section II.F.2; III.B.3	Adds language to require an SRG to meet a performance measure in the Pay-for-Value program to receive SRP payments.	Shared risk settlement payments must be tied to specific, measurable quality outcomes to qualify as medical expenses in MLR reporting.
Section II.J	Adds language allowing adjustments to a shared risk settlement for a closed period.	Allows for adjustments to closed shared risk years due to federal or state adjustments.

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Recommended Action 2: New Policy

CalOptima Health Policy FF.4003: Vendor Exclusion and Preclusion Monitoring is a new policy that establishes requirements for verifying and monitoring vendor eligibility to participate in state and/or federal health care programs. The new policy defines:

- Procedures for initial and ongoing screening against federal and state exclusion and preclusion lists;
- Responsibilities of CalOptima Health departments for vendor monitoring and compliance review; and
- Actions to be taken by CalOptima Health when a vendor is identified as excluded, precluded, or otherwise ineligible to participate in a government-funded health care programs.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

The recommended action will allow CalOptima Health's finance policies to align with federal and state regulations and current operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy FF.1006: Financial Risk Arrangements
2. CalOptima Health Policy FF.1010: Shared Risk Pool
3. CalOptima Health Policy MA.3003: Medicare Shared Risk Pool
4. CalOptima Health Policy FF.4003: Vendor Exclusion and Preclusion Monitoring

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Policy:	FF.1006
Title:	**Financial Risk Arrangements**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy describes the process by which CalOptima Health ensures that financial risk arrangements set forth in Hospital Risk Pool Arrangements and Other Risk Arrangements are fair, equitable, and appropriately reward Providers for cost-effective, high-quality services to Members assigned to a Physician Hospital Consortium (PHC).

II. POLICY

A. Hospital Risk Pool Arrangements

1. If CalOptima Health requires a PHC to establish a Hospital Risk Pool Arrangement, the PHC shall do so pursuant to the terms and conditions of this Policy.

2. A PHC shall establish a hospital risk pool funded by hospital capitation dollars paid by CalOptima Health.

3. A Primary Physician Group shall be entitled to a minimum of fifty percent (50%) of any hospital risk pool surplus.

4. A Primary Physician Group's downside risk shall be limited to five percent (5%) of the Primary Physician Group's total Capitation Payment.

5. CalOptima Health shall ensure PHC compliance with Hospital Risk Pool Arrangements and may impose Sanctions, including Capitation Payment deductions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

B. All Hospital Risk Pool Arrangements and Other Risk Arrangements developed by a PHC shall comply with the following:

1. A PHC shall design Hospital Risk Pool Arrangements and Other Risk Arrangements primarily to create incentives for Providers;

2. Effective January 1, 2027, a PHC shall ensure that distributions from Hospital Risk Pool Arrangements and Other Risk Arrangements are tied to measurable quality outcomes and have a

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defined performance period related to specific Health Network Medical Loss Ratio (MLR) reporting periods.

~~2.~~3. A PHC shall facilitate a common understanding and high level of trust between the various parties of Hospital Risk Pool Arrangements and Other Risk Arrangements and shall make such Hospital Risk Pool Arrangements and Other Risk Arrangements as administratively simple as possible;

~~3.~~4. A PHC shall ensure that Hospital Risk Pool Arrangements and Other Risk Arrangements are compliant with federal and state law;

~~4.~~5. A PHC shall not structure Hospital Risk Pool Arrangements or Other Risk Arrangements to deny or limit access or jeopardize quality of care;

~~5.~~6. A PHC shall ensure that each contracting Provider has the administrative and financial capacity to meet its contractual obligations; and

~~6.~~7. A PHC shall have a mechanism to detect and correct under-service by an at-risk Provider, including possible underutilization of specialist services and preventive health care services.

C. A PHC shall ensure that Hospital Risk Pool Arrangements and Other Risk Arrangements are agreed to by written contract and signed by all parties and shall submit signed Hospital Risk Pool Arrangements and Other Risk Arrangements to CalOptima Health and its Contracted Vendor upon initial set-up, following subsequent revisions, and upon request.

D. CalOptima Health or its Contracted Vendor shall review and provide comments, as necessary, on the appropriateness of a PHC's Hospital Risk Pool Arrangements and Other Risk Arrangements pursuant to the terms and conditions of this Policy.

III. PROCEDURE

A. A PHC shall document a Hospital Risk Pool Arrangement in a risk pool agreement. The risk pool agreement shall be agreed to, and signed by, both the Primary Physician Group and Primary Hospital, and shall delineate the following minimum provisions:

1. Risk pool funding sources (i.e., hospital Capitation Payments, reinsurance recoveries, coordination of benefit collections);

2. Services that are debited against the risk pool;

3. Valuation of services debited against the risk pool;

4. Surplus sharing;

5. Deficit sharing;

6. Calculation period and settlements;

7. Effective January 1, 2027, measurable quality outcomes that the Primary Physician Group must meet in order to receive the distribution payment; and

~~7.~~8. Dispute resolution.

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B. Calculations and settlements related to Hospital Risk Pool Arrangements

1. A PHC shall perform risk pool settlement calculations on a quarterly basis, and shall obtain signatures from the Primary Physician Group, Primary Hospital, and any other participating entities on the calculations.

2. A PHC shall provide copies of all quarterly or other interim settlement calculations to CalOptima Health, or its Contracted Vendor as requested during any annual financial audits and/or reviews.

3. A PHC shall calculate annual settlements for a given contract year, acquire signatures from representatives of the participating entities, issue payment per the timeline defined in the Hospital Risk Pool Arrangement, and submit the annual settlements and proof of the payments to CalOptima Health or its Contracted Vendor as part of the annual review of the PHC's Medical Loss Ratio calculation.

C. Written communication to a Provider regarding Other Risk Arrangements

1. A PHC shall provide clear, written communication to a Provider regarding Other Risk Arrangements and any risk pool settlements.

2. A PHC shall provide a Provider with a copy of the risk pool settlement calculation, and

a. The calculation of the Provider's particular risk pool dollar share amount; or

b. A written explanation as to why the Provider is not eligible for a distribution under the Other Risk Arrangement.

D. CalOptima Health's oversight of Hospital Risk Pool Arrangements and Other Risk Arrangements

1. CalOptima Health or its Contracted Vendor shall receive and review, upon request or as part of any financial audit and/or review, all settlement calculations and payment distributions to ensure that a PHC is compliant with the terms of the approved Hospital Risk Pool Arrangements and Other Risk Arrangements and the provisions of this policy.

2. If a PHC is non-compliant with any of the provisions in Section II of this policy, CalOptima Health shall require a PHC to submit a Corrective Action Plan (CAP) as appropriate, in accordance with CalOptima Health Policy HH.2005 Corrective Action Plan. CalOptima Health may impose Sanctions, including Capitation Payment deductions, in accordance with CalOptima Health Policy HH.2002: Sanctions, if PHC continues to be non-compliant with any of the provisions in Section II of this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health, Health Network Service Agreement
B. CalOptima Health Policy HH.2002: Sanctions
C. CalOptima Health Policy HH.2005: Corrective Action Plan

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D. Title 28, California Code of Regulations (C.C.R.), §§1300.70(b)(2)(H)(1) and (2)a.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Version	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	09/01/2014	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2016	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Reviewed	05/01/2017	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	07/01/2018	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	06/04/2020	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	08/01/2021	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	12/31/2022	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	07/01/2023	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2024	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2025	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised		FF.1006	Financial Risk Arrangements	Medi-Cal

For 2026

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.
Corrective Action Plan (CAP)	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), 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 other requirements identified by CalOptima Health and its regulators.
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, 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;

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Term	Definition
	3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and

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Term	Definition
	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.
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.
Hospital Risk Pool Arrangements	A risk arrangement contractually required by CalOptima Health between a physician and hospital partner funded by hospital capitation dollars paid by CalOptima Health.
Member	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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Other Risk Arrangements	A risk arrangement between Health Network partner or Health Network participants outside of a Hospital Risk Pool Arrangement.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima Health's Contract for Health Care Services.
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).
Program	Any of CalOptima's programs including the CalOptima Health Medi-Cal Program, OneCare, PACE, or the Multipurpose Senior Services Program.
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.
Sanction	An 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, and/or other requirements related to CalOptima Health Programs.

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For 20261105 BOD Review Only

Policy:	FF.1006
Title:	**Financial Risk Arrangements**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy describes the process by which CalOptima Health ensures that financial risk arrangements set forth in Hospital Risk Pool Arrangements and Other Risk Arrangements are fair, equitable, and appropriately reward Providers for cost-effective, high-quality services to Members assigned to a Physician Hospital Consortium (PHC).

II. POLICY

A. Hospital Risk Pool Arrangements

1. If CalOptima Health requires a PHC to establish a Hospital Risk Pool Arrangement, the PHC shall do so pursuant to the terms and conditions of this Policy.

2. A PHC shall establish a hospital risk pool funded by hospital capitation dollars paid by CalOptima Health.

3. A Primary Physician Group shall be entitled to a minimum of fifty percent (50%) of any hospital risk pool surplus.

4. A Primary Physician Group's downside risk shall be limited to five percent (5%) of the Primary Physician Group's total Capitation Payment.

5. CalOptima Health shall ensure PHC compliance with Hospital Risk Pool Arrangements and may impose Sanctions, including Capitation Payment deductions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

B. All Hospital Risk Pool Arrangements and Other Risk Arrangements developed by a PHC shall comply with the following:

1. A PHC shall design Hospital Risk Pool Arrangements and Other Risk Arrangements primarily to create incentives for Providers;

2. Effective January 1, 2027, a PHC shall ensure that distributions from Hospital Risk Pool Arrangements and Other Risk Arrangements are tied to measurable quality outcomes and have a

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defined performance period related to specific Health Network Medical Loss Ratio (MLR) reporting periods.

3. A PHC shall facilitate a common understanding and high level of trust between the various parties of Hospital Risk Pool Arrangements and Other Risk Arrangements and shall make such Hospital Risk Pool Arrangements and Other Risk Arrangements as administratively simple as possible;

4. A PHC shall ensure that Hospital Risk Pool Arrangements and Other Risk Arrangements are compliant with federal and state law;

5. A PHC shall not structure Hospital Risk Pool Arrangements or Other Risk Arrangements to deny or limit access or jeopardize quality of care;

6. A PHC shall ensure that each contracting Provider has the administrative and financial capacity to meet its contractual obligations; and

7. A PHC shall have a mechanism to detect and correct under-service by an at-risk Provider, including possible underutilization of specialist services and preventive health care services.

C. A PHC shall ensure that Hospital Risk Pool Arrangements and Other Risk Arrangements are agreed to by written contract and signed by all parties and shall submit signed Hospital Risk Pool Arrangements and Other Risk Arrangements to CalOptima Health and its Contracted Vendor upon initial set-up, following subsequent revisions, and upon request.

D. CalOptima Health or its Contracted Vendor shall review and provide comments, as necessary, on the appropriateness of a PHC's Hospital Risk Pool Arrangements and Other Risk Arrangements pursuant to the terms and conditions of this Policy.

III. PROCEDURE

A. A PHC shall document a Hospital Risk Pool Arrangement in a risk pool agreement. The risk pool agreement shall be agreed to, and signed by, both the Primary Physician Group and Primary Hospital, and shall delineate the following minimum provisions:

1. Risk pool funding sources (i.e., hospital Capitation Payments, reinsurance recoveries, coordination of benefit collections);

2. Services that are debited against the risk pool;

3. Valuation of services debited against the risk pool;

4. Surplus sharing;

5. Deficit sharing;

6. Calculation period and settlements;

7. Effective January 1, 2027, measurable quality outcomes that the Primary Physician Group must meet in order to receive the distribution payment; and

8. Dispute resolution.

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B. Calculations and settlements related to Hospital Risk Pool Arrangements

1. A PHC shall perform risk pool settlement calculations on a quarterly basis, and shall obtain signatures from the Primary Physician Group, Primary Hospital, and any other participating entities on the calculations.

2. A PHC shall provide copies of all quarterly or other interim settlement calculations to CalOptima Health, or its Contracted Vendor as requested during any annual financial audits and/or reviews.

3. A PHC shall calculate annual settlements for a given contract year, acquire signatures from representatives of the participating entities, issue payment per the timeline defined in the Hospital Risk Pool Arrangement, and submit the annual settlements and proof of the payments to CalOptima Health or its Contracted Vendor as part of the annual review of the PHC's Medical Loss Ratio calculation.

C. Written communication to a Provider regarding Other Risk Arrangements

1. A PHC shall provide clear, written communication to a Provider regarding Other Risk Arrangements and any risk pool settlements.

2. A PHC shall provide a Provider with a copy of the risk pool settlement calculation, and

a. The calculation of the Provider's particular risk pool dollar share amount; or

b. A written explanation as to why the Provider is not eligible for a distribution under the Other Risk Arrangement.

D. CalOptima Health's oversight of Hospital Risk Pool Arrangements and Other Risk Arrangements

1. CalOptima Health or its Contracted Vendor shall receive and review, upon request or as part of any financial audit and/or review, all settlement calculations and payment distributions to ensure that a PHC is compliant with the terms of the approved Hospital Risk Pool Arrangements and Other Risk Arrangements and the provisions of this policy.

2. If a PHC is non-compliant with any of the provisions in Section II of this policy, CalOptima Health shall require a PHC to submit a Corrective Action Plan (CAP) as appropriate, in accordance with CalOptima Health Policy HH.2005 Corrective Action Plan. CalOptima Health may impose Sanctions, including Capitation Payment deductions, in accordance with CalOptima Health Policy HH.2002: Sanctions, if PHC continues to be non-compliant with any of the provisions in Section II of this policy.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health, Health Network Service Agreement
B. CalOptima Health Policy HH.2002: Sanctions
C. CalOptima Health Policy HH.2005: Corrective Action Plan

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D. Title 28, California Code of Regulations (C.C.R.), §§1300.70(b)(2)(H)(1) and (2)a.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Version	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	09/01/2014	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2016	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Reviewed	05/01/2017	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	07/01/2018	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	06/04/2020	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	08/01/2021	FF.1006	Financial Risk Arrangements	Medi-Cal OneCare Connect
Revised	12/31/2022	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	07/01/2023	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2024	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised	08/01/2025	FF.1006	Financial Risk Arrangements	Medi-Cal
Revised		FF.1006	Financial Risk Arrangements	Medi-Cal

For 2020

IX. GLOSSARY

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Term	Definition
	3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and

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Term	Definition
	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.
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Member	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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Other Risk Arrangements	A risk arrangement between Health Network partner or Health Network participants outside of a Hospital Risk Pool Arrangement.
Physician Hospital Consortium (PHC)	A Physician Group or Physician Groups contractually aligned with at least one (1) hospital, as described in CalOptima Health's Contract for Health Care Services.
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).
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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.
Sanction	An 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, and/or other requirements related to CalOptima Health Programs.

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For 20261105 BOD Review Only

Policy:	FF.1010
Title:	**Shared Risk Pool**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	07/01/2008
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

For 2026 1105 BOD Review Only

I. PURPOSE

This policy outlines the process for CalOptima Health's administration of the Shared Risk Pool with a Shared Risk Group.

II. POLICY

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

B. CalOptima Health shall establish a Shared Risk Pool each fiscal year (July 1 through June 30) during the term of a Shared Risk Group's Contract for Health Care Services.

C. The Shared Risk Budget shall include:

1. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within the applicable period;

2. Reinsurance recovery amounts as set forth in CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage; and

3. For deliveries after June 30, 2023, the Shared Risk Budget shall include Supplemental OB Delivery Care payments in accordance with terms and conditions set forth in the Shared Risk Group's Contract.

D. Effective July 1, 2023, the Shared Risk Budget shall include any amounts for Health Network Members eligible for the California Children's Services (CCS) Program.

E. Shared Risk Expenses shall include:

1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

2. An estimate of Incurred But Not Reported (IBNR) expenses for Shared Risk Services; and

3. Administrative expenses at a rate established in the Contract for Health Care Services.

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F. Shared Risk Expenses shall not include:

1. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Health Policy FF.1005c: Special Payments – High Cost Exclusion Items.

2. Any expenses for services rendered prior to July 1, 2023, attributable to the Health Network Members who are eligible for the CCS Program.

G. Quarterly Reporting - CalOptima Health shall report the status of the Shared Risk Pool to its corresponding Shared Risk Group within forty-five (45) calendar days following the end of each quarter as follows:

1. Quarter Ending September 30: Due November 15.

2. Quarter Ending December 31: Due February 15.

3. Quarter Ending March 31: Due May 15.

4. Quarter Ending June 30: Due August 15.

H. Semi-Annual Reconciliation and Settlement - CalOptima Health shall reconcile and settle the Shared Risk Pool by February 28 following the immediately preceding semi-annual period of July 1 through December 31.

1. If, at the end of the first semi-annual period of the fiscal year, CalOptima Health determines that the Shared Risk Pool is in surplus, CalOptima Health shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits carried forward from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

2. If, at the end of that semi-annual period, CalOptima Health determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

3. Effective January 1, 2027, Semi-Annual Reconciliation and Settlement payments require minimum performance of the twenty-fifth (25th) percentile in aggregate for the selected measures within the most recent final CalOptima Health Pay-for-Value (P4V) program as the gateway for a Shared Risk Pool payment. In the event the twenty-fifth (25th) percentile of performance is not achieved, no payment shall be made.

I. Annual Reconciliation and Settlement - CalOptima Health shall reconcile and report the status of the Shared Risk Pool by October 31 following the end of each fiscal year. The Shared Risk Group will have thirty (30) calendar days from the date of receipt of the annual report to notify CalOptima Health of any objections to the calculations of the surplus or deficit, as detailed in Section III.C.4. of this Policy.

1. After issuance of the final Annual Shared Risk Program Report, if CalOptima Health determines that the Shared Risk Pool is in surplus, CalOptima Health shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section II.H.1. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima Health shall retain the balance of the Shared Risk Pool.

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2. After issuance of the final Annual Shared Risk Program Report, if CalOptima Health determines that the Shared Risk Pool is in deficit, CalOptima Health shall carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

3. Effective January 1, 2027, Annual Reconciliation and Settlement require minimum performance of the twenty-fifth (25th) percentile in aggregate for the selected measures within the most recent final CalOptima Health Pay-for-Value (P4V) program as the gateway for a Shared Risk Pool payment. In the event the twenty-fifth (25th) percentile of performance is not achieved, no payment shall be made.

J. If there is a significant change in risk pool performance, CalOptima Health reserves the right to meet with the Shared Risk Group in order to discuss and understand the reason for the significant change.

K. If there is continued deterioration of performance of the Shared Risk Pool, CalOptima Health may request a Corrective Action Plan (CAP) from the Shared Risk Group.

L. If CalOptima Health determines that a Shared Risk Group has Shared Risk Pool deficits in two (2) successive fiscal years, CalOptima Health may terminate the Shared Risk Group's Contract for Health Care Services.

M. In the event that CalOptima Health or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima Health shall settle the Shared Risk Pool within one hundred twenty (120) calendar days following the date of contract termination, in accordance with Section III.D. of this Policy.

N. Upon identification of a payment error, Shared Risk Groups must submit written notification on a timely basis in order for CalOptima Health to seek necessary Provider recoupment. CalOptima Health cannot request recoupment from a Provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima Health's original claims payment.

O. If a Health Network identifies an overpayment of a semi-annual or annual settlement payment, the Health Network 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 Health Network on the process to return the overpayment.

P. Effective January 1, 2027, in the event that DHCS notifies and adjusts funding from the closed shared risk reporting period for Members assigned to Shared Risk Group, CalOptima Health shall reserve the right to make adjustments to shared risk settlement accordingly.

III. PROCEDURE

A. Quarterly Shared Risk Pool Reporting

1. Within forty-five (45) calendar days following the end of each quarter, as detailed in section II.G. of this Policy, CalOptima Health shall provide a Shared Risk Group with a written report of the status of the Shared Risk Pool.

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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 fiscal year; and

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

B. Semi-Annual Shared Risk Pool Reconciliation and Settlement

1. No later than February 28 of each year, CalOptima Health shall settle the Shared Risk Pool for the immediately preceding semi-annual period July 1 through December 31.

   a. CalOptima Health shall calculate the Shared Risk Budget for the semi-annual period July 1 through December 31. The Shared Risk Budget shall include all components detailed in Sections II.C. and II.D. of this Policy related to Members assigned to the Shared Risk Group within the semi-annual period, and for dates of service within the semi-annual period.

   b. CalOptima Health shall calculate Shared Risk Expenses for the semi-annual period July 1 through December 31. The Shared Risk Expenses shall include all components detailed in Sections II.E. and II.F. of this Policy for dates of service within the semi-annual period.

   c. CalOptima Health shall reduce Shared Risk Expenses for the semi-annual period by:

      i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima Health or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group within the semi-annual period; and

      ii. Any recoveries, including overpayments, for dates of service within the semi-annual period related to Shared Risk Services provided to Members assigned to the Shared Risk Group.

2. CalOptima Health shall compute and settle the semi-annual Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the semi-annual period.

   a. If CalOptima Health determines that the Shared Risk Pool is in surplus, CalOptima Health shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

   b. If CalOptima Health determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

   c. CalOptima Health shall confirm that minimum quality performance for the health network is achieved in CalOptima Health's most recent and final pay-for-value program prior to making any pool payment as described in Section II.H.3 of this policy.

C. Annual Shared Risk Pool Reconciliation and Settlement

1. No later than October 31 of each year, CalOptima Health shall provide the Shared Risk Group with an Annual Shared Risk Program Report. The Annual Shared Risk Program Report shall

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show reconciliation of allocations, deposits, expenses, and disbursements during the immediately preceding fiscal year, and the status of the Shared Risk Pool.

a. CalOptima Health shall calculate the Shared Risk Budget for the annual reconciliation in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the fiscal year shall include:

   i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year, including any retroactivity within ninety (90) calendar days after the end of the fiscal year;

   ii. Reinsurance recovery amounts for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year; and

   iii. Supplemental OB Delivery Care payments for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year.

b. CalOptima Health shall calculate Shared Risk Expenses for the annual reconciliation in accordance with Sections II.E. and II.F. of this Policy. Shared Risk Expenses for the fiscal year shall include:

   i. Claims for Shared Risk Services for dates of service within that fiscal year and paid within ninety (90) calendar days following the end of the fiscal year;

   ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the end of the fiscal year; and

   iii. Administrative expenses as established in the Contract for Health Care Services.

c. Shared Risk Expenses shall not include:

   i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Health Policy FF.1005c: Special Payments – High Cost Exclusion Items.

d. CalOptima Health shall reduce Shared Risk Expenses for the fiscal 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 assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the end of the fiscal year; and

   ii. Any recoveries, including overpayments, for dates of service within that fiscal year related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the end of the fiscal year.

e. If CalOptima Health identifies any Shared Risk Expenses past ninety (90) calendar days following the end of the fiscal year, CalOptima Health shall deduct such Shared Risk Expenses from the Shared Risk Budget as part of the subsequent fiscal year's update for that Shared Risk Period pursuant to Section III.C.3. of this Policy.

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f. CalOptima Health shall confirm that minimum quality performance for the health network is achieved in CalOptima Health's most recent and final pay-for-value program prior to making any pool payment as described in Section II.I.3 of this policy.

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 fiscal year.

   a. If CalOptima Health determines that the Shared Risk Pool is in surplus, the Annual Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section III.B.2.a. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima Health shall retain the balance of the Shared Risk Pool.

   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 carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

3. Each Annual Shared Risk Program Report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima Health shall refresh the Annual Shared Risk Program Report at the time of the following shared risk period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed Annual Shared Risk Program Report should not contain IBNR and shall be considered final. (e.g., FY16 Shared Risk Period [July 1, 2015-June 30, 2016] will be final October 31, 2018).

4. If, upon review of the Annual Shared Risk Program Report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and 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 Shared Risk Group within thirty (30) calendar days of receipt of the Annual Shared Risk Program Report, CalOptima Health shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, no later than December 15. Such settlement shall be considered final.

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

   c. CalOptima Health shall settle the Shared Risk Pool based on this final Annual Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final Annual Shared Risk Program Report.

D. Shared Risk Pool Settlement upon Termination

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1. Within one hundred twenty (120) calendar days after the effective date of termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima Health shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

    a. CalOptima Health shall calculate the Shared Risk Budget for the reconciliation upon termination in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the reconciliation upon termination shall include:

        i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year and up to the effective date of termination, including any retroactivity within ninety (90) calendar days after the effective date of termination;

        ii. Reinsurance coverage amounts for dates of service within the fiscal year and up to the effective date of termination, identified no later than ninety (90) calendar days after the effective date of termination; and

        iii. OB Delivery Care payments for dates of service within that fiscal year and up to the effective date of termination, identified within ninety (90) calendar days after the effective date of termination.

    b. CalOptima Health shall calculate Shared Risk Expenses for the reconciliation upon termination in accordance with Sections II.E and II.F of this Policy. Shared Risk Expenses for the reconciliation upon termination shall include:

        i. Claims for Shared Risk Services for dates of service within that fiscal year and up to the effective date of termination, paid within ninety (90) calendar days following the effective date of termination;

        ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year and up to the effective date of termination, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the effective date of termination; and

        iii. Administrative expenses as established in the Contract for Health Care Services.

    c. Shared Risk Expenses shall not include:

        i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Health Policy FF.1005.c: Special Payments – High Cost Exclusion Items.

    d. CalOptima Health shall reduce Shared Risk Expenses for the fiscal 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 assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the effective date of termination; and

        ii. Any recoveries, including overpayments, for dates of service within that fiscal year and up to the effective date of termination related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the effective date of termination.

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

    a. If CalOptima Health determines that the Shared Risk Pool is in surplus, the Final Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less amounts paid at the semi-annual reconciliation period (if applicable), and less any deficits from the previous annual settlement, if not already subtracted at the semi-annual reconciliation period. CalOptima Health shall retain the balance of the Shared Risk Pool.

    b. If CalOptima Health determines that the Shared Risk Pool is in deficit, in accordance with CalOptima Health's contract with the Shared Risk Group, CalOptima Health shall recoup such deficit by either:

        i. Offsetting the deficit amounts from any current or future amount owed by CalOptima Health to the physician group, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses; or

        ii. Sending an invoice to the physician group that payment for such deficit is due to CalOptima Health within thirty (30) days of physician group's receipt of the CalOptima Health invoice.

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

    a. If CalOptima Health does not receive any written objection from the Shared Risk Group within thirty (30) calendar days from the date of receipt of the Final Shared Risk Program Report, CalOptima Health shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final.

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

    c. CalOptima Health shall settle the Shared Risk Pool based on the revised Final Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the revised Final Shared Risk Program Report.

IV. ATTACHMENT(S)

Not Applicable
~~A. Risk Pool Claims Objection Form~~

V. REFERENCE(S)

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A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy FF.1005c: Special Payments – High-Cost Exclusion Items
D. CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage
E. CalOptima Health Policy FF.2003: Coordination of Benefits
F. Risk Pool Claims Objection Form

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/14/2011	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
10/02/2014	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2008	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2009	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2010	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/01/2014	FF.1010	Shared Risk Pool	Medi-Cal
Revised	08/01/2016	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2017	FF.1010	Shared Risk Pool	Medi-Cal
Revised	10/04/2018	FF.1010	Shared Risk Pool	Medi-Cal
Revised	06/04/2020	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2021	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2022	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2023	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2024	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2025	FF.1010	Shared Risk Pool	Medi-Cal
Revised		FF.1010	Shared Risk Pool	Medi-Cal

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IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Contracted CalOptima Health Hospital	A hospital that has entered into a CalOptima Health Hospital Services Contract to provide hospital services to CalOptima Health Direct Members.
Contract for Health Care Services	The written instrument between CalOptima Health and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include all applicable DHCS Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and any Memoranda of Understanding entered into by CalOptima Health that are binding on a Physician Hospital Consortium (PHC), a physician group under a shared risk contract, or an HMO.
Coordination of Benefits (COB)	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Corrective Action Plan (CAP)	A plan delineating specific and 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 State, or designated representatives. Health Networks and Providers may be required to complete a CAP to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
High Cost Exclusion Item	Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.
Hospital Budget Capitation Allocation	The amount equal to the Hospital Risk Pool Capitation (PMPM) set forth in the contract multiplied by the number of Members assigned to the Shared Risk Physician.
Incurred But Not Reported (IBNR)	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.
Member	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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
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.
Shared Risk Budget	The total amount that CalOptima Health allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.

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Term	Definition
Shared Risk Expenses	Includes: 1. Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; 2. An estimate of Incurred but Not Reported (IBNR) expenses; 3. Administrative expenses at a rate established in the Contract for Health Care Services; and 4. Any reinsurance premiums paid by CalOptima Health allocable to the Shared Risk Group.
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.
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 Physician.

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Policy:	FF.1010
Title:	**Shared Risk Pool**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	07/01/2008
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☒ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy outlines the process for CalOptima Health's administration of the Shared Risk Pool with a Shared Risk Group.

II. POLICY

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

B. CalOptima Health shall establish a Shared Risk Pool each fiscal year (July 1 through June 30) during the term of a Shared Risk Group's Contract for Health Care Services.

C. The Shared Risk Budget shall include:

1. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within the applicable period;

2. Reinsurance recovery amounts as set forth in CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage; and

3. For deliveries after June 30, 2023, the Shared Risk Budget shall include Supplemental OB Delivery Care payments in accordance with terms and conditions set forth in the Shared Risk Group's Contract.

D. Effective July 1, 2023, the Shared Risk Budget shall include any amounts for Health Network Members eligible for the California Children's Services (CCS) Program.

E. Shared Risk Expenses shall include:

1. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

2. An estimate of Incurred But Not Reported (IBNR) expenses for Shared Risk Services; and

3. Administrative expenses at a rate established in the Contract for Health Care Services.

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F. Shared Risk Expenses shall not include:

1. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Health Policy FF.1005c: Special Payments – High Cost Exclusion Items.

2. Any expenses for services rendered prior to July 1, 2023, attributable to the Health Network Members who are eligible for the CCS Program.

G. Quarterly Reporting - CalOptima Health shall report the status of the Shared Risk Pool to its corresponding Shared Risk Group within forty-five (45) calendar days following the end of each quarter as follows:

1. Quarter Ending September 30: Due November 15.

2. Quarter Ending December 31: Due February 15.

3. Quarter Ending March 31: Due May 15.

4. Quarter Ending June 30: Due August 15.

H. Semi-Annual Reconciliation and Settlement - CalOptima Health shall reconcile and settle the Shared Risk Pool by February 28 following the immediately preceding semi-annual period of July 1 through December 31.

1. If, at the end of the first semi-annual period of the fiscal year, CalOptima Health determines that the Shared Risk Pool is in surplus, CalOptima Health shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits carried forward from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

2. If, at the end of that semi-annual period, CalOptima Health determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

3. Effective January 1, 2027, Semi-Annual Reconciliation and Settlement payments require minimum performance of the twenty-fifth (25^{th}) percentile in aggregate for the selected measures within the most recent final CalOptima Health Pay-for-Value (P4V) program as the gateway for a Shared Risk Pool payment. In the event the twenty-fifth (25^{th}) percentile of performance is not achieved, no payment shall be made.

I. Annual Reconciliation and Settlement - CalOptima Health shall reconcile and report the status of the Shared Risk Pool by October 31 following the end of each fiscal year. The Shared Risk Group will have thirty (30) calendar days from the date of receipt of the annual report to notify CalOptima Health of any objections to the calculations of the surplus or deficit, as detailed in Section III.C.4. of this Policy.

1. After issuance of the final Annual Shared Risk Program Report, if CalOptima Health determines that the Shared Risk Pool is in surplus, CalOptima Health shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section II.H.1. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima Health shall retain the balance of the Shared Risk Pool.

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2. After issuance of the final Annual Shared Risk Program Report, if CalOptima Health determines that the Shared Risk Pool is in deficit, CalOptima Health shall carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

3. Effective January 1, 2027, Annual Reconciliation and Settlement require minimum performance of the twenty-fifth (25^{th}) percentile in aggregate for the selected measures within the most recent final CalOptima Health Pay-for-Value (P4V) program as the gateway for a Shared Risk Pool payment. In the event the twenty-fifth (25^{th}) percentile of performance is not achieved, no payment shall be made.

J. If there is a significant change in risk pool performance, CalOptima Health reserves the right to meet with the Shared Risk Group in order to discuss and understand the reason for the significant change.

K. If there is continued deterioration of performance of the Shared Risk Pool, CalOptima Health may request a Corrective Action Plan (CAP) from the Shared Risk Group.

L. If CalOptima Health determines that a Shared Risk Group has Shared Risk Pool deficits in two (2) successive fiscal years, CalOptima Health may terminate the Shared Risk Group's Contract for Health Care Services.

M. In the event that CalOptima Health or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima Health shall settle the Shared Risk Pool within one hundred twenty (120) calendar days following the date of contract termination, in accordance with Section III.D. of this Policy.

N. Upon identification of a payment error, Shared Risk Groups must submit written notification on a timely basis in order for CalOptima Health to seek necessary Provider recoupment. CalOptima Health cannot request recoupment from a Provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima Health's original claims payment.

O. If a Health Network identifies an overpayment of a semi-annual or annual settlement payment, the Health Network 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 Health Network on the process to return the overpayment.

P. Effective January 1, 2027, in the event that DHCS notifies and adjusts funding from the closed shared risk reporting period for Members assigned to Shared Risk Group, CalOptima Health shall reserve the right to make adjustments to shared risk settlement accordingly.

III. PROCEDURE

A. Quarterly Shared Risk Pool Reporting

1. Within forty-five (45) calendar days following the end of each quarter, as detailed in section II.G. of this Policy, CalOptima Health shall provide a Shared Risk Group with a written report of the status of the Shared Risk Pool.

2. The report shall include:

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

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

B. Semi-Annual Shared Risk Pool Reconciliation and Settlement

1. No later than February 28 of each year, CalOptima Health shall settle the Shared Risk Pool for the immediately preceding semi-annual period July 1 through December 31.

a. CalOptima Health shall calculate the Shared Risk Budget for the semi-annual period July 1 through December 31. The Shared Risk Budget shall include all components detailed in Sections II.C. and II.D. of this Policy related to Members assigned to the Shared Risk Group within the semi-annual period, and for dates of service within the semi-annual period.

b. CalOptima Health shall calculate Shared Risk Expenses for the semi-annual period July 1 through December 31. The Shared Risk Expenses shall include all components detailed in Sections II.E. and II.F. of this Policy for dates of service within the semi-annual period.

c. CalOptima Health shall reduce Shared Risk Expenses for the semi-annual period by:

i. Any applicable copayments, deductibles, or third-party payments collected by CalOptima Health or a Provider for Shared Risk Services provided to Members assigned to the Shared Risk Group within the semi-annual period; and

ii. Any recoveries, including overpayments, for dates of service within the semi-annual period related to Shared Risk Services provided to Members assigned to the Shared Risk Group.

2. CalOptima Health shall compute and settle the semi-annual Shared Risk Pool surplus or deficit by deducting the Shared Risk Expenses from the Shared Risk Budget for the semi-annual period.

a. If CalOptima Health determines that the Shared Risk Pool is in surplus, CalOptima Health shall pay the Shared Risk Group an amount equal to sixty percent (60%) of that surplus, less any deficits from the previous annual settlement. Any surplus distributions are an advance against the projected final surplus. The remaining forty percent (40%) of the surplus shall remain in the Shared Risk Pool.

b. If CalOptima Health determines that the Shared Risk Pool is in deficit, no advance payment shall be made to the Shared Risk Group.

c. CalOptima Health shall confirm that minimum quality performance for the health network is achieved in CalOptima Health's most recent and final pay-for-value program prior to making any pool payment as described in Section II.H.3 of this policy.

C. Annual Shared Risk Pool Reconciliation and Settlement

1. No later than October 31 of each year, CalOptima Health shall provide the Shared Risk Group with an Annual Shared Risk Program Report. The Annual Shared Risk Program Report shall

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show reconciliation of allocations, deposits, expenses, and disbursements during the immediately preceding fiscal year, and the status of the Shared Risk Pool.

a. CalOptima Health shall calculate the Shared Risk Budget for the annual reconciliation in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the fiscal year shall include:

   i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year, including any retroactivity within ninety (90) calendar days after the end of the fiscal year;

   ii. Reinsurance recovery amounts for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year; and

   iii. Supplemental OB Delivery Care payments for dates of service within that fiscal year and identified within ninety (90) calendar days after the end of the fiscal year.

b. CalOptima Health shall calculate Shared Risk Expenses for the annual reconciliation in accordance with Sections II.E. and II.F. of this Policy. Shared Risk Expenses for the fiscal year shall include:

   i. Claims for Shared Risk Services for dates of service within that fiscal year and paid within ninety (90) calendar days following the end of the fiscal year;

   ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the end of the fiscal year; and

   iii. Administrative expenses as established in the Contract for Health Care Services.

c. Shared Risk Expenses shall not include:

   i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Health Policy FF.1005c: Special Payments – High Cost Exclusion Items.

d. CalOptima Health shall reduce Shared Risk Expenses for the fiscal 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 assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the end of the fiscal year; and

   ii. Any recoveries, including overpayments, for dates of service within that fiscal year related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the end of the fiscal year.

e. If CalOptima Health identifies any Shared Risk Expenses past ninety (90) calendar days following the end of the fiscal year, CalOptima Health shall deduct such Shared Risk Expenses from the Shared Risk Budget as part of the subsequent fiscal year's update for that Shared Risk Period pursuant to Section III.C.3. of this Policy.

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f. CalOptima Health shall confirm that minimum quality performance for the health network is achieved in CalOptima Health's most recent and final pay-for-value program prior to making any pool payment as described in Section II.I.3 of this policy.

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 fiscal year.

   a. If CalOptima Health determines that the Shared Risk Pool is in surplus, the Annual Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less any advance amounts paid at the semi-annual reconciliation period as described in Section III.B.2.a. of this Policy, and less any deficits carried forward from the previous annual settlement. CalOptima Health shall retain the balance of the Shared Risk Pool.

   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 carry forward an amount equal to sixty percent (60%) of that deficit into the next fiscal year's semi-annual and/or annual reconciliation, along with any additional deficits carried forward from the previous annual settlement, except as otherwise established in the Contract for Health Care Services.

3. Each Annual Shared Risk Program Report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima Health shall refresh the Annual Shared Risk Program Report at the time of the following shared risk period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed Annual Shared Risk Program Report should not contain IBNR and shall be considered final. (e.g., FY16 Shared Risk Period [July 1, 2015-June 30, 2016] will be final October 31, 2018).

4. If, upon review of the Annual Shared Risk Program Report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and 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 Shared Risk Group within thirty (30) calendar days of receipt of the Annual Shared Risk Program Report, CalOptima Health shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, no later than December 15. Such settlement shall be considered final.

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

   c. CalOptima Health shall settle the Shared Risk Pool based on this final Annual Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final Annual Shared Risk Program Report.

D. Shared Risk Pool Settlement upon Termination

For 20201105 BOD Review Only

1. Within one hundred twenty (120) calendar days after the effective date of termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima Health shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

    a. CalOptima Health shall calculate the Shared Risk Budget for the reconciliation upon termination in accordance with Sections II.C. and II.D. of this Policy. The Shared Risk Budget for the reconciliation upon termination shall include:

        i. The Hospital Budget Capitation Allocation for Members assigned to the Shared Risk Group within that fiscal year and up to the effective date of termination, including any retroactivity within ninety (90) calendar days after the effective date of termination;

        ii. Reinsurance coverage amounts for dates of service within the fiscal year and up to the effective date of termination, identified no later than ninety (90) calendar days after the effective date of termination; and

        iii. OB Delivery Care payments for dates of service within that fiscal year and up to the effective date of termination, identified within ninety (90) calendar days after the effective date of termination.

    b. CalOptima Health shall calculate Shared Risk Expenses for the reconciliation upon termination in accordance with Sections II.E and II.F of this Policy. Shared Risk Expenses for the reconciliation upon termination shall include:

        i. Claims for Shared Risk Services for dates of service within that fiscal year and up to the effective date of termination, paid within ninety (90) calendar days following the effective date of termination;

        ii. An estimate of IBNR expenses for Shared Risk Services rendered within that fiscal year and up to the effective date of termination, based on historical claims for Shared Risk Services for dates of service within that fiscal year and paid up to ninety (90) calendar days following the effective date of termination; and

        iii. Administrative expenses as established in the Contract for Health Care Services.

    c. Shared Risk Expenses shall not include:

        i. Reimbursement for a High Cost Exclusion Item as set forth in CalOptima Health Policy FF.1005.c: Special Payments – High Cost Exclusion Items.

    d. CalOptima Health shall reduce Shared Risk Expenses for the fiscal 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 assigned to the Shared Risk Group during that fiscal year within ninety (90) calendar days after the effective date of termination; and

        ii. Any recoveries, including overpayments, for dates of service within that fiscal year and up to the effective date of termination related to Shared Risk Services provided to Members assigned to the Shared Risk Group and received within ninety (90) calendar days after the effective date of termination.

For 20261105 BOD Review Only

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

    a. If CalOptima Health determines that the Shared Risk Pool is in surplus, the Final Shared Risk Program Report shall reflect that the amount payable to the Shared Risk Group will be an amount equal to sixty percent (60%) of that surplus, less amounts paid at the semi-annual reconciliation period (if applicable), and less any deficits from the previous annual settlement, if not already subtracted at the semi-annual reconciliation period. CalOptima Health shall retain the balance of the Shared Risk Pool.

    b. If CalOptima Health determines that the Shared Risk Pool is in deficit, in accordance with CalOptima Health's contract with the Shared Risk Group, CalOptima Health shall recoup such deficit by either:

        i. Offsetting the deficit amounts from any current or future amount owed by CalOptima Health to the physician group, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses; or

        ii. Sending an invoice to the physician group that payment for such deficit is due to CalOptima Health within thirty (30) days of physician group's receipt of the CalOptima Health invoice.

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

    a. If CalOptima Health does not receive any written objection from the Shared Risk Group within thirty (30) calendar days from the date of receipt of the Final Shared Risk Program Report, CalOptima Health shall settle the Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final.

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

    c. CalOptima Health shall settle the Shared Risk Pool based on the revised Final Shared Risk Program Report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the revised Final Shared Risk Program Report.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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

For 20261105 BOD Review Only

B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy FF.1005c: Special Payments – High-Cost Exclusion Items
D. CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage
E. CalOptima Health Policy FF.2003: Coordination of Benefits
F. Risk Pool Claims Objection Form

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/14/2011	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
10/02/2014	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2008	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2009	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2010	FF.1010	Shared Risk Pool	Medi-Cal
Revised	09/01/2014	FF.1010	Shared Risk Pool	Medi-Cal
Revised	08/01/2016	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2017	FF.1010	Shared Risk Pool	Medi-Cal
Revised	10/04/2018	FF.1010	Shared Risk Pool	Medi-Cal
Revised	06/04/2020	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2021	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2022	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2023	FF.1010	Shared Risk Pool	Medi-Cal
Revised	05/01/2024	FF.1010	Shared Risk Pool	Medi-Cal
Revised	07/01/2025	FF.1010	Shared Risk Pool	Medi-Cal
Revised		FF.1010	Shared Risk Pool	Medi-Cal

For Review Only

IX. GLOSSARY

Term	Definition
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Contracted CalOptima Health Hospital	A hospital that has entered into a CalOptima Health Hospital Services Contract to provide hospital services to CalOptima Health Direct Members.
Contract for Health Care Services	The written instrument between CalOptima Health and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include all applicable DHCS Medi-Cal Managed Care Division Policy Letters and All Plan Letters, and any Memoranda of Understanding entered into by CalOptima Health that are binding on a Physician Hospital Consortium (PHC), a physician group under a shared risk contract, or an HMO.
Coordination of Benefits (COB)	A method for determining the order of payment for medical or other care/treatment benefits where the primary health plan pays for covered benefits as it would without the presence of a secondary health plan.
Corrective Action Plan (CAP)	A plan delineating specific and 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 State, or designated representatives. Health Networks and Providers may be required to complete a CAP to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
High Cost Exclusion Item	Specific high-cost items that are excluded from a Contracted Hospital's outpatient reimbursement or inpatient per diem rate.
Hospital Budget Capitation Allocation	The amount equal to the Hospital Risk Pool Capitation (PMPM) set forth in the contract multiplied by the number of Members assigned to the Shared Risk Physician.
Incurred But Not Reported (IBNR)	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.
Member	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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
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.
Shared Risk Budget	The total amount that CalOptima Health allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.

For 2026 10/6 BOD Review Only

Term	Definition
Shared Risk Expenses	Includes: 1. Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; 2. An estimate of Incurred but Not Reported (IBNR) expenses; 3. Administrative expenses at a rate established in the Contract for Health Care Services; and 4. Any reinsurance premiums paid by CalOptima Health allocable to the Shared Risk Group.
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.
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 Physician.

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For 20261105 BOD Review Only

Policy:	MA.3003
Title:	**Medicare Shared Risk Pool**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	01/01/2021
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy outlines the process for CalOptima Health's administration of a Medicare Shared Risk Pool with a Shared Risk Group.

II. POLICY

A. CalOptima Health shall establish the Medicare Shared Risk Pool for the Shared Risk Group in accordance with the Contract for Health Care Services and the terms and conditions of this Policy.

B. CalOptima Health shall establish the Medicare Shared Risk Pool each calendar year (CY) during the term of the Shared Risk Group's Contract for Health Care Services.

C. Medicare Shared Risk Budget:

1. The Medicare Shared Risk Budget shall be established based on the Medicare Hospital Budget allocated for Members assigned to the Shared Risk Group within the applicable period.

D. Medicare Shared Risk Expenses:

1. The Medicare Shared Risk Expenses shall include:

a. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

b. An estimate of Incurred But Not Reported (IBNR) claims for Shared Risk Services; and

c. Deduction for any recoveries related to Shared Risk Services, including but not limited to copayments, overpayment recoveries and coordination of benefit recoveries.

E. Quarterly Medicare Shared Risk Reporting:

1. CalOptima Health shall report the status of the Medicare Shared Risk Pool to its corresponding Shared Risk Group within thirty (30) calendar days following the end of each quarter as follows:

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a. Period Ending January 1 to March 31: Due April 30.

b. Period Ending January 1 to June 30: Due July 31.

c. Period Ending January 1 to September 30: Due October 31.

d. Period Ending January 1 to December 31: Due January 31.

F. Annual Medicare Shared Risk Reconciliation and Settlement:

1. By April 30, CalOptima Health shall distribute an annual report of the Medicare Shared Risk Program for the preceding CY to the Shared Risk Group. Upon an acceptance of the annual report from the Shared Risk Group, CalOptima Health shall settle the Medicare Shared Risk Pool for:

a. Surplus. If Medicare Shared Risk Expenses are less than Medicare Shared Risk Budget, CalOptima Health shall pay a Shared Risk Group an amount equal to fifty percent (50%) of that surplus, less any deficits carried forward from the previous annual settlement. CalOptima Health shall retain the balance of the Shared Risk Pool.

b. Deficit. If Medicare Shared Risk Expenses exceed Medicare Shared Risk Budget, CalOptima Health shall carry forward an amount equal to fifty percent (50%) of that deficit, up to an amount not to exceed $5.00 per Enrollee per month calculated on CY basis, into the next annual reconciliation, along with any additional deficits carried forward from the previous annual settlement.

2. Effective January 1, 2027, Annual Medicare Shared Risk Reconciliation and Settlement payments require minimum performance of the twenty-fifth (25th) percentile in aggregate for the selected measures within the most recent final CalOptima Health Pay-for-Value (P4V) program as the gateway for a Shared Risk Pool payment. In the event the twenty-fifth (25th) percentile of performance is not achieved, no payment shall be made.

G. In the event that CalOptima Health or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima Health shall settle the Medicare Shared Risk Pool within one hundred twenty (120) calendar days following the annualized capitation adjustment (also known as Hierarchical Condition Category (HCC) sweeps) of the CY of the termination of the Contract for Health Care Services with a Shared Risk Group, in accordance with Section III.C. of this Policy. If the Medicare Shared Risk Pool settlement calculation results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima Health shall recoup by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses.

H. Upon identification of a payment error, the Shared Risk Group must submit a written notification on a timely basis in order for CalOptima Health to seek necessary provider recoupment. CalOptima Health cannot request recoupment from a provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima Health's original claims payment.

I. If the Shared Risk Group identifies an overpayment of an annual settlement payment, the Shared Risk Group 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 Shared Risk Group on the process to return the overpayment.

For 2026 1105 BOD Review Only

J. Effective January 1, 2027, in the event that CMS notifies and adjusts funding from the closed shared risk reporting period for Members assigned to Shared Risk Group, CalOptima Health shall reserve the right to make adjustments to shared risk settlement accordingly.

III. PROCEDURE

A. Quarterly Medicare Shared Risk Reporting:

1. Within thirty (30) calendar days following the end of each quarter, as detailed in section II.F. of this Policy, CalOptima Health shall provide the Shared Risk Group with a written report of the status of the Shared Risk Pool.

2. The quarterly report shall estimate the projected Medicare Shared Risk Budget, Expenses, and Surplus or Deficit as described in sections II.C., D., and E. of this Policy, for the reporting period.

B. Annual Medicare Shared Risk Reconciliation and Settlement:

1. No later than April 30 of each year, CalOptima Health shall provide the Shared Risk Group with an annual report. The annual report shall show the status of the Medicare Shared Risk Pool for the immediately preceding CY.

2. CalOptima Health shall compute the annual Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit as described in sections II.C., D. and, E. of this Policy.

3. CalOptima Health shall confirm that minimum quality performance for the health network is achieved in CalOptima Health's most recent and final P4V program prior to making any pool payment as described in Section II.F.2 of this policy.

~~3.~~4. Each annual report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima Health shall refresh the annual report at the time of the following Shared Risk Period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed annual Shared Risk Program report should not contain IBNR and shall be considered final. (e.g., CY2021 Shared Risk Period will be final April 30, 2024).

~~4.~~5. If, upon review of the annual report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Health Accounting Department within thirty (30) calendar days from the date of receipt of the annual report.

a. If CalOptima Health does not receive any written objection from the Shared Risk Group within thirty (30) calendar days of receipt of the annual report, CalOptima Health shall settle the Medicare Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, but no later than June 15. Such settlement shall be considered final.

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

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c. CalOptima Health shall settle the Medicare Shared Risk Pool based on this final annual report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final annual report.

~~5.~~6. If CalOptima Health determines that a Shared Risk Group has Medicare Shared Risk Pool deficits in two (2) successive fiscal years, or if there is a significant change in risk pool performance, CalOptima Health may meet with the Shared Risk Group in order to discuss and understand the reason for the pool deficits and develop an improvement plan.

C. Medicare Shared Risk Settlement upon Termination:

1. Within one hundred twenty (120) calendar days after the annualized capitation adjustment (also known as HCC sweeps) of the CY of the termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima Health shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

2. CalOptima Health shall compute the Final Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit in accordance with Section II.C., D. and, E.

3. The Final Reconciliation and Settlement Report shall include refreshed reports from the previous two (2) annual shared risk periods. Or, CalOptima Health shall refresh any annual report which otherwise would not be considered final as of the effective date of termination of the Contract for Health Care Services with the Shared Risk Group.

4. If, upon review of the Final Reconciliation and Settlement Report, the terminated Shared Risk Group objects to the calculations and determination, the terminated Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Health Accounting Department within thirty (30) calendar days from the date of receipt of the Final Reconciliation and Settlement Report.

   a. If CalOptima Health does not receive any written objection from the terminated Shared Risk Group within thirty (30) calendar days of receipt of the Final Reconciliation and Settlement Report, CalOptima Health shall settle the Medicare Shared Risk Pool within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final. If the settlement calculation from the Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima Health shall recoup by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses.

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

   c. CalOptima Health shall settle the Medicare Shared Risk Pool based on this revised Final Reconciliation and Settlement Report within fifteen (15) calendar days after the date of issuance of the revised Final Reconciliation and Settlement Report. If the settlement calculation from the revised Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima Health shall recoup by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses.

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IV. ATTACHMENT(S)

Not Applicable
~~A. Risk Pool Claims Objection Form~~

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.A. Medicare Physician Group Service Agreement~~
~~C.~~B. CalOptima Health Policy FF.2003: Coordination of Benefits
C. Medicare Physician Group Service Agreement
D. Risk Pool Claims Objection Form
E. Title 42, Code of Federal Regulations (CFR) §§ 422.2430, 422.2440

VI. REGULATORY AGENCY APPROVAL(S)

None To Date

VII. BOARD ACTION(S)

Date	Meeting
08/05/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2021	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	05/01/2022	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	09/01/2022	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	06/01/2023	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	05/01/2024	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	10/01/2025	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised		MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect

For Review Only

IX. GLOSSARY

Term	Definition
Contracted CalOptima Health Hospital	A hospital that has entered into a CalOptima Health Hospital Services Contract to provide hospital services to CalOptima Health Direct Members.
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.
Covered Services	OneCare & OneCare Connect: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to 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.
Medicare Hospital Budget	The amount equal to the Non-Part D related capitation that CalOptima Health receives from Center for Medicare & Medicaid Services (CMS) for Members assigned to the Shared Risk Physician multiplied by Hospital Budget percentage set forth in the Shared Risk Group Contract for Health Care Services.
Medicare Shared Risk Pool	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.
Member	~~A beneficiary~~An individual enrolled in a CalOptima Health program.
Provider	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.
Shared Risk Budget	The total amount that CalOptima Health allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.
Shared Risk Expenses	Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; and Administrative expenses at a rate established in the Contract for Health Care Services.
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.
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 the contracted Health Network.

For 20261105 BOD Review Only

Term	Definition
Shared Risk Services	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.

For 20261105 BOD Review Only

Policy:	MA.3003
Title:	**Medicare Shared Risk Pool**
Department:	Finance
Section:	Accounting
CEO Approval:	*/s/*
Effective Date:	01/01/2021
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California [Effective 2027] ☐ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE

For 20261105 BOD Review Only

I. PURPOSE

This policy outlines the process for CalOptima Health's administration of a Medicare Shared Risk Pool with a Shared Risk Group.

II. POLICY

A. CalOptima Health shall establish the Medicare Shared Risk Pool for the Shared Risk Group in accordance with the Contract for Health Care Services and the terms and conditions of this Policy.

B. CalOptima Health shall establish the Medicare Shared Risk Pool each calendar year (CY) during the term of the Shared Risk Group's Contract for Health Care Services.

C. Medicare Shared Risk Budget:

1. The Medicare Shared Risk Budget shall be established based on the Medicare Hospital Budget allocated for Members assigned to the Shared Risk Group within the applicable period.

D. Medicare Shared Risk Expenses:

1. The Medicare Shared Risk Expenses shall include:

a. Claims paid for Shared Risk Services provided to Members assigned to the Shared Risk Group;

b. An estimate of Incurred But Not Reported (IBNR) claims for Shared Risk Services; and

c. Deduction for any recoveries related to Shared Risk Services, including but not limited to copayments, overpayment recoveries and coordination of benefit recoveries.

E. Quarterly Medicare Shared Risk Reporting:

1. CalOptima Health shall report the status of the Medicare Shared Risk Pool to its corresponding Shared Risk Group within thirty (30) calendar days following the end of each quarter as follows:

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a. Period Ending January 1 to March 31: Due April 30.

b. Period Ending January 1 to June 30: Due July 31.

c. Period Ending January 1 to September 30: Due October 31.

d. Period Ending January 1 to December 31: Due January 31.

F. Annual Medicare Shared Risk Reconciliation and Settlement:

1. By April 30, CalOptima Health shall distribute an annual report of the Medicare Shared Risk Program for the preceding CY to the Shared Risk Group. Upon an acceptance of the annual report from the Shared Risk Group, CalOptima Health shall settle the Medicare Shared Risk Pool for:

a. Surplus. If Medicare Shared Risk Expenses are less than Medicare Shared Risk Budget, CalOptima Health shall pay a Shared Risk Group an amount equal to fifty percent (50%) of that surplus, less any deficits carried forward from the previous annual settlement. CalOptima Health shall retain the balance of the Shared Risk Pool.

b. Deficit. If Medicare Shared Risk Expenses exceed Medicare Shared Risk Budget, CalOptima Health shall carry forward an amount equal to fifty percent (50%) of that deficit, up to an amount not to exceed $5.00 per Enrollee per month calculated on CY basis, into the next annual reconciliation, along with any additional deficits carried forward from the previous annual settlement.

2. Effective January 1, 2027, Annual Medicare Shared Risk Reconciliation and Settlement payments require minimum performance of the twenty-fifth (25^{th}) percentile in aggregate for the selected measures within the most recent final CalOptima Health Pay-for-Value (P4V) program as the gateway for a Shared Risk Pool payment. In the event the twenty-fifth (25^{th}) percentile of performance is not achieved, no payment shall be made.

G. In the event that CalOptima Health or a Shared Risk Group terminates the Contract for Health Care Services, CalOptima Health shall settle the Medicare Shared Risk Pool within one hundred twenty (120) calendar days following the annualized capitation adjustment (also known as Hierarchical Condition Category (HCC) sweeps) of the CY of the termination of the Contract for Health Care Services with a Shared Risk Group, in accordance with Section III.C. of this Policy. If the Medicare Shared Risk Pool settlement calculation results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima Health shall recoup by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses.

H. Upon identification of a payment error, the Shared Risk Group must submit a written notification on a timely basis in order for CalOptima Health to seek necessary provider recoupment. CalOptima Health cannot request recoupment from a provider after more than three hundred sixty-five (365) calendar days from the date of CalOptima Health's original claims payment.

I. If the Shared Risk Group identifies an overpayment of an annual settlement payment, the Shared Risk Group 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 Shared Risk Group on the process to return the overpayment.

For 2026 10/7 BOD Review Only

J. Effective January 1, 2027, in the event that CMS notifies and adjusts funding from the closed shared risk reporting period for Members assigned to Shared Risk Group, CalOptima Health shall reserve the right to make adjustments to shared risk settlement accordingly.

III. PROCEDURE

A. Quarterly Medicare Shared Risk Reporting:

1. Within thirty (30) calendar days following the end of each quarter, as detailed in section II.F. of this Policy, CalOptima Health shall provide the Shared Risk Group with a written report of the status of the Shared Risk Pool.

2. The quarterly report shall estimate the projected Medicare Shared Risk Budget, Expenses, and Surplus or Deficit as described in sections II.C., D., and E. of this Policy, for the reporting period.

B. Annual Medicare Shared Risk Reconciliation and Settlement:

1. No later than April 30 of each year, CalOptima Health shall provide the Shared Risk Group with an annual report. The annual report shall show the status of the Medicare Shared Risk Pool for the immediately preceding CY.

2. CalOptima Health shall compute the annual Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit as described in sections II.C., D. and, E. of this Policy.

3. CalOptima Health shall confirm that minimum quality performance for the health network is achieved in CalOptima Health's most recent and final P4V program prior to making any pool payment as described in Section II.F.2 of this policy.

4. Each annual report shall include refreshed reports from the previous two (2) annual shared risk periods. CalOptima Health shall refresh the annual report at the time of the following Shared Risk Period's annual settlement to update IBNR and actual claims payment for previous shared risk periods. After two (2) years, the refreshed annual Shared Risk Program report should not contain IBNR and shall be considered final. (e.g., CY2021 Shared Risk Period will be final April 30, 2024).

5. If, upon review of the annual report, the Shared Risk Group objects to the calculations and determination, the Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Health Accounting Department within thirty (30) calendar days from the date of receipt of the annual report.

   a. If CalOptima Health does not receive any written objection from the Shared Risk Group within thirty (30) calendar days of receipt of the annual report, CalOptima Health shall settle the Medicare Shared Risk Pool and apply any surplus or deficit within fifteen (15) calendar days after the expiration of the review period, but no later than June 15. Such settlement shall be considered final.

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

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c. CalOptima Health shall settle the Medicare Shared Risk Pool based on this final annual report and apply any surplus or deficit within fifteen (15) calendar days after the date of issuance of the final annual report.

6. If CalOptima Health determines that a Shared Risk Group has Medicare Shared Risk Pool deficits in two (2) successive fiscal years, or if there is a significant change in risk pool performance, CalOptima Health may meet with the Shared Risk Group in order to discuss and understand the reason for the pool deficits and develop an improvement plan.

C. Medicare Shared Risk Settlement upon Termination:

1. Within one hundred twenty (120) calendar days after the annualized capitation adjustment (also known as HCC sweeps) of the CY of the termination of the Contract for Health Care Services with a Shared Risk Group, CalOptima Health shall provide the terminated Shared Risk Group with a Final Reconciliation and Settlement Report.

2. CalOptima Health shall compute the Final Medicare Shared Risk Pool Budget, Expenses, and Surplus or Deficit in accordance with Section II.C., D. and, E.

3. The Final Reconciliation and Settlement Report shall include refreshed reports from the previous two (2) annual shared risk periods. Or, CalOptima Health shall refresh any annual report which otherwise would not be considered final as of the effective date of termination of the Contract for Health Care Services with the Shared Risk Group.

4. If, upon review of the Final Reconciliation and Settlement Report, the terminated Shared Risk Group objects to the calculations and determination, the terminated Shared Risk Group may complete and submit the Risk Pool Claims Objection Form and any supporting documentation to the CalOptima Health Accounting Department within thirty (30) calendar days from the date of receipt of the Final Reconciliation and Settlement Report.

a. If CalOptima Health does not receive any written objection from the terminated Shared Risk Group within thirty (30) calendar days of receipt of the Final Reconciliation and Settlement Report, CalOptima Health shall settle the Medicare Shared Risk Pool within fifteen (15) calendar days after the expiration of the review period. Such settlement shall be considered final. If the settlement calculation from the Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima Health shall recoup by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses.

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

c. CalOptima Health shall settle the Medicare Shared Risk Pool based on this revised Final Reconciliation and Settlement Report within fifteen (15) calendar days after the date of issuance of the revised Final Reconciliation and Settlement Report. If the settlement calculation from the revised Final Reconciliation and Settlement Report results in a deficit, in accordance with the Contract with the Shared Risk Group, CalOptima Health shall recoup by offsetting deficit amounts against capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or Shared Risk Pool surpluses.

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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Policy FF.2003: Coordination of Benefits
C. Medicare Physician Group Service Agreement
D. Risk Pool Claims Objection Form
E. Title 42, Code of Federal Regulations (CFR) §§ 422.2430, 422.2440

VI. REGULATORY AGENCY APPROVAL(S)

None To Date

VII. BOARD ACTION(S)

Date	Meeting
08/05/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2021	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	05/01/2022	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	09/01/2022	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	06/01/2023	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	05/01/2024	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised	10/01/2025	MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect
Revised		MA.3003	Medicare Shared Risk Pool	OneCare OneCare Connect

For Review Only

IX. GLOSSARY

Term	Definition
Contracted CalOptima Health Hospital	A hospital that has entered into a CalOptima Health Hospital Services Contract to provide hospital services to CalOptima Health Direct Members.
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.
Covered Services	OneCare & OneCare Connect: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima Health identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima Health and the County of Orange.
Incurred But Not Reported (IBNR)	IBNR means "incurred but not reported," and refers to 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.
Medicare Hospital Budget	The amount equal to the Non-Part D related capitation that CalOptima Health receives from Center for Medicare & Medicaid Services (CMS) for Members assigned to the Shared Risk Physician multiplied by Hospital Budget percentage set forth in the Shared Risk Group Contract for Health Care Services.
Medicare Shared Risk Pool	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.
Member	An individual enrolled in a CalOptima Health program.
Provider	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.
Shared Risk Budget	The total amount that CalOptima Health allocates to the Shared Risk Pool to pay for Shared Risk Services set forth in the DOFR of the contract.
Shared Risk Expenses	Amounts paid for Shared Risk Services provided to Members assigned to the Shared Risk Group; An estimate of Incurred But Not Reported (IBNR) expenses; and Administrative expenses at a rate established in the Contract for Health Care Services.
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.
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 the contracted Health Network.

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Term	Definition
Shared Risk Services	Covered Services which are the financial responsibility under the Hospital Budget as set forth in the Division of Financial Responsibility (DOFR) of the Contract for Health Care Services.

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Policy:	FF.4003
Title:	**Vendor Exclusion and Preclusion Monitoring**
Department:	Finance
Section:	N/A
CEO Approval:	*/s/*
Effective Date:	07/01/2026
Revised Date:	
Applicable to:	☐ Administrative ☐ Covered California ☒ Medi-Cal ☒ OneCare ☒ PACE

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I. PURPOSE

This policy outlines a process for verifying and monitoring, the eligibility of a Vendor, to participate in CalOptima Health state and/or federal health care programs using state and federal Exclusions and Preclusion lists.

II. POLICY

A. CalOptima Health shall ensure all Vendor(s) are eligible to participate in CalOptima Health state and/or federal health care programs, and shall be responsible for:

1. Requiring Vendor to disclose and report pending suspensions, Exclusions, Preclusions, or debarments.

2. Conducting the initial eligibility verification of Vendor prior to entering or renewing in any new agreement with CalOptima Health, or issuing payment thereto;

3. Performing eligibility verification of Vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

5. Denying or terminating already established contractual relationships with individuals or entities that are determined to be suspended, debarred, excluded, or precluded from participation in state or federal health care programs. Individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality can remain contracted with CalOptima Health as long as the individuals or entities are not listed on the state and federal Exclusions and Preclusion list including:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medi-Cal's Suspended and Ineligible (S&I) list;

   c. Medi-Cal Restricted Provider Database (RPD);

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d. OIG Exclusion Database (OIG LEIE Database);

e. CMS Preclusion List

B. CalOptima Health shall utilize state and federal Exclusions and Preclusion list sources referenced in Section II.A.5 of this Policy to verify the eligibility of Vendor and shall maintain a record of completion.

C. CalOptima Health shall not reimburse an individual or entity that is verified to be suspended, debarred, excluded, or precluded from participation in state and/or federal health care programs.

D. CalOptima Health will take immediate appropriate actions, with the assistance of its Legal Counsel, including up to terminating the contractual relationship with Vendor for all CalOptima Health programs, if such individual or entity is verified to be suspended, debarred, Excluded or Precluded from participation in state and/or federal health care programs.

E. All CalOptima Health Vendor(s) shall verify the eligibility of all its Employees and/or Downstream Entities prior to hiring/contracting/performing services and monthly thereafter. The Vendor(s) shall maintain a record of completion.

F. In the event a CalOptima Health Vendor identifies its employees and/or Downstream Entities on an Exclusion, and/or Preclusion list, the Vendor must immediately notify CalOptima Health of the identified ineligible person/entity. CalOptima Health in its sole discretion will determine whether it is appropriate to immediately suspend/remove/terminate the identified person/entity from furnishing items and services for CalOptima Health programs and/or suspend/terminate the applicable vendor contract.

G. CalOptima Health may contract with a Subcontractor that has been suspended or excluded from participation in the Medi-Cal program when the suspension and/or exclusion has been lifted.

III. PROCEDURE

A. Evidence of Verification

1. CalOptima Health shall utilize applicable state and federal Exclusions and Preclusion list sources referenced in Section II.A.5 of this Policy to verify the eligibility of a Vendor and shall maintain a record of completion for the initial and monthly verification indicating:

a. The date of verification;

b. The Exclusion and Preclusion list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

B. Initial Verification

1. Prior to contracting with any prospective Vendor, Vendor Management shall verify that the individual or entity is not listed on the state and federal Exclusions and Preclusion list sources referenced in Section II.A.5 of this Policy.

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2. If CalOptima Health intends to deny a prospective Vendor participation in CalOptima Health program(s) on the basis of an Exclusion or Preclusion, it shall notify the Vendor in writing, noting the reason for denial. The prospective vendor may contest the denial if they feel there is an error or inappropriate Exclusion. If CalOptima Health determines that there is an inappropriate Exclusion, correction shall be made.

C. Monthly Monitoring

1. On a monthly basis, Accounting shall verify that Vendor(s) existing in Financial System, are not listed on the state and federal Exclusions and Preclusion list sources referenced in Section II.A.5 of this Policy.

2. Actions Based on Discovery of Exclusion List

a. Accounting shall notify appropriate CalOptima Health departments of the Excluded or ineligible individual or entity. Accounting shall refer the matter to the Office of Compliance for further investigation and appropriate action in accordance with Regulatory and CalOptima Health policies.

b. CalOptima Health shall immediately suspend and halt all payments to that Vendor. CalOptima Health may recoup monies paid to the Vendor while Excluded.

c. If CalOptima Health intends to terminate an existing Vendor's contract on the basis of Exclusion, it shall notify the Vendor in writing, noting the reason for termination. The existing Vendor may contest the termination if they feel there is an error or inappropriate Exclusion. If CalOptima Health determines that there is an inappropriate Exclusion, correction shall be made.

d. If a previously Excluded Vendor has been re-instated by a Monitoring source listed on Section II.A.5 of this Policy and is now in good standing and able to participate in CalOptima Health state and/or federal health care programs, the Vendor may express interest in participating with CalOptima Health. CalOptima Health will require evidence to verify reinstatement into state and/or federal funded health care programs. In addition, the Vendor will undergo re-processing through contracting and/or Credentialing.

3. Actions Based on Discovery of CMS Preclusion List

a. Accounting shall notify appropriate CalOptima Health departments of the Precluded or ineligible individual or entity. Accounting shall refer the matter to the Office of Compliance for further investigation and appropriate action in accordance with Regulatory and CalOptima Health policies.

b. CalOptima Health should not deny payments and/or reject claims earlier than ninety (90) calendar days after publication of the associated Preclusion list. CalOptima Health may recoup monies paid to the Vendor while Precluded.

c. For Vendor identified on both the Exclusion sources and the CMS Preclusion List, CalOptima Health's processes for an Excluded individual or entity supersedes those of a Precluded individual or entity.

d. If CalOptima Health intends to terminate an existing Vendor's contract on the basis of Preclusion, it shall notify the Vendor in writing, noting the reason for termination. The existing Vendor may contest the termination if they feel there is an error or inappropriate

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Exclusion. If CalOptima Health determines that there is an inappropriate Preclusion, correction shall be made.

e. If a previously Precluded Vendor has been re-instated by a Monitoring source listed on Section II.A.5 of this Policy and is now in good standing and able to participate in CalOptima Health state and/or federal health care programs, the Vendor may express interest in participating with CalOptima Health. CalOptima Health will require evidence to verify reinstatement into state and/or federal funded health care programs. In addition, the Vendor will undergo re-processing through contracting and/or Credentialing.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Supersedes APL 16-001)
F. Medicare Managed Care Manual, Chapter 21
G. Medicare Prescription Drug Benefit Manual, Chapter 9
H. Medicaid Program Integrity Manual, Revised June 19, 2020
I. Medicare Program Integrity Manual, Chapter 4, Revised July 27, 2020
J. Sections 1128 and 156 of the Social Security Act
K. Title 42, Code of Federal Regulations (CFR), §§422.222, 422.224, and 423.120(c)(6)
L. Title 42, Code of Federal Regulations (CFR), §1001.1901
M. Title 42, United States Code (US.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
N. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2026	FF.4003	Vendor Exclusion and Preclusion Monitoring	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Downstream Entity	For purposes of this policy, any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Monitoring	An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a 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.
Vendor	For purposes of this policy, Vendor must meet both requirements: 1. Individual or Entity who have no contractual relationship with CalOptima Health or who have already or potentially signed a contract with CalOptima Health through Vendor Management. 2. Individual or Entity must already or potentially be created in Financial System to receive payments from CalOptima Health.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

17. Authorize Funding for Independent Audit Services Pursuant to Assembly Bill 2194

Contacts

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

Recommended Action

Authorize unbudgeted expenditures in an amount up to $2.0 million from undesignated reserves to fund an independent, external audit of CalOptima Health's governance procedures and practices, pursuant to Section 14087.591 of the Welfare and Institutions Code, as amended and added by Assembly Bill 2194 (2026).

Background

On September 27, 2026, California Governor Gavin Newsom signed into law Assembly Bill (AB) 2194, authored by California State Assemblymember Avelino Valencia. AB 2194 was unanimously passed by the California State Senate on August 24, 2026, and by the California State Assembly on August 26, 2026. After several amendments and advocacy positions since AB 2194 was first introduced on February 19, 2026, the CalOptima Health Board of Directors (Board) ultimately adopted a neutral position on the final version of the bill at its regular meeting on August 6, 2026.

The enacted text of AB 2194 (Attachment 1) includes the following two major provisions affecting CalOptima Health's governance:

1. Implements staggered terms for the seven Board seats with four-year terms (*i.e.*, all regular voting seats except those held by the two Directors on the Orange County Board of Supervisors), effective for the next terms expected to begin in August 2028, to improve the continuity of CalOptima Health's governance. The three seats subject to initial, transitional two-year terms at that time are:
    - Community clinic representative;
    - Practicing licensed medical provider who is not affiliated with a health network; and
    - Accounting or public finance professional or actively licensed attorney.

2. Requires an independent, external audit of CalOptima Health's governance procedures and practices, with a final audit report to be submitted to the California State Legislature and the California Department of Health Care Services (DHCS) by July 1, 2027.

The statutory timeline for completing the governance audit requires immediate Board action to ensure adequate time for procurement, fieldwork, analysis, and reporting before the deadline.

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Discussion

To comply with AB 2194 requirements, staff released a Request for Proposals (RFP) for independent governance audit services in September 2026. To encourage broader participation, staff extended the RFP submission deadline once to October 26, 2026. Staff will evaluate the proposals and select a qualified firm to complete the governance audit, in accordance with the Board-approved CalOptima Health Policy GA.5002: Purchasing, and will submit a final audit report to the California State Legislature and DHCS by July 1, 2027.

The estimated cost of the engagement is approximately $2.0 million. Should the final cost of the selected proposal exceed this estimate, staff will return to the Board for approval of additional funding prior to contract execution.

Fiscal Impact

The recommended actions are unbudgeted. An appropriation of up to $2.0 million from undesignated reserves will fund these actions.

Rationale for Recommendation

Authorizing funding to conduct an independent, external audit of CalOptima Health's governance procedures and practices is necessary to meet the requirements of AB 2194.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. AB 2194 Enacted Text

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STATE OF CALIFORNIA
AUTHENTICATED
ELECTRONIC LEGAL MATERIAL

Assembly Bill No. 2194

CHAPTER 588

An act to amend Section 14087.59 of, and to add Section 14087.591 to, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 27, 2026. Filed with Secretary of State September 27, 2026.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2194, Valencia. Medi-Cal: special commissions.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes a county board of supervisors to establish a commission to negotiate an exclusive contract with the department to provide, or arrange for the provision of, health care services under the Medi-Cal program.

Pursuant to the authority described above, the County of Orange established a commission and existing law established the governance of that commission, known as the Orange County Health Authority or CalOptima, to provide health care services under the Medi-Cal program. Existing law prescribes who can serve on the 10-member governing body of the commission and requires each member to serve a 4-year term, except as described.

This bill, for terms commencing after January 1, 2027, would impose one-, 2-, and 4-year terms of office, as specified. The bill would also prohibit specified voting members from serving more than two consecutive terms and from serving in that capacity for more than 10 consecutive years. The bill would require the governing body of the Orange County Health Authority to authorize and pay for an independent external audit of its governance procedures and practices, including the roles and responsibilities of the governing body, executive leadership, and staff, among others. The bill would require the audit to be completed by July 1, 2027, and would require that a copy of the report be provided to the Legislature and made public. Because this bill would impose a unique requirement on how services are provided on a local government and would require additional duties of county authorities, the bill would impose a state-mandated local program.

This bill would make legislative findings and declarations as to the necessity of a special statute for County of Orange.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

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This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 14087.59 of the Welfare and Institutions Code is amended to read:

14087.59. (a) (1) Notwithstanding subdivision (d) of Section 14087.54, governance of the commission in the County of Orange established pursuant to Section 14087.54, known as the Orange County Health Authority, shall be vested in a governing body consisting of 10 members: 9 voting members and 1 nonvoting member. The nonvoting member shall be the Director of the Orange County Health Care Agency. The nine voting members shall be nominated by the Orange County Health Care Agency and appointed by a majority vote of the Board of Supervisors of the County of Orange and shall consist of the following:

(A) Two members shall each be a member of the Board of Supervisors of the County of Orange, with one additional member of the Board of Supervisors of the County of Orange to serve as an alternate.

(B) One member shall be a current or former hospital administrator.

(C) One member shall be a representative of a community clinic, which may include, but is not limited to, a representative of a federally qualified health center, as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code.

(D) One member shall be a member of the public who is a legal resident of the County of Orange.

(E) One member shall be a practicing licensed medical provider who is not an owner or officer, or a member of the board of directors, of a contracted independent physician's association or provider network.

(F) One member shall be a current Orange County Health Authority member or a family member of a current Orange County Health Authority member.

(G) One member shall be an accounting or public finance professional, or an attorney who is an active member of the State Bar.

(H) One member shall be a practicing licensed physician who is a representative of a contracted independent physician's association or provider network.

(2) For purposes of identifying qualified individuals to be considered as members of the governing body, the Board of Supervisors of the County of Orange shall consult with stakeholders in the County of Orange, including, but not limited to, providers who serve CalOptima members, consumers, and advocates.

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(b) Each member of the governing body shall reside in, or be employed in, the County of Orange and shall be generally representative of the diverse backgrounds, interests, and demography of persons residing in the County of Orange. Each member of the governing body shall have a commitment to a health care system that seeks to improve access to high-quality health care for persons served by the commission and that in fact delivers high-quality care and is financially viable. Each member shall possess the requisite skills and knowledge necessary to design and operate a quality publicly assisted health care delivery system.

(c) In order to stagger the terms of the voting members of the governing body, for terms commencing after January 1, 2027, the term of office shall be as follows:

(1) Members of the governing body described in subparagraphs (B), (D), (F), and (H) of paragraph (1) of subdivision (a) shall serve a term of office of four years.

(2) For the first new term commencing after January 1, 2027, members of the governing body described in subparagraphs (C), (E), and (G) of paragraph (1) of subdivision (a) shall serve a term of office of two years. Thereafter, the term of office shall be for four years.

(3) Members of the governing body described in subparagraph (A) of paragraph (1) of subdivision (a) shall serve a term of office of one year.

(4) Members who are appointed to fill the unexpired term of a vacant seat shall have an initial term that corresponds to the unexpired term of the vacant seat. A vacancy that occurs in the last 90 days of a term shall not be filled until the expiration of the term.

(5) A member of the governing body described in subparagraphs (B) to (H), inclusive, of paragraph (1) of subdivision (a) shall not serve more than two consecutive 4-year terms and shall not serve in that capacity for more than 10 consecutive years.

(6) A member serving on the governing body pursuant to subparagraph (A) of paragraph (1) of subdivision (a) shall not be appointed to serve as a member pursuant to subparagraphs (B) to (H), inclusive, of paragraph (1) of subdivision (a) within 12 months of the expiration of their one-year term.

(7) A member of the governing body of the commission may be removed from the governing body by a vote in favor of that removal of at least two-thirds of the full membership of the Board of Supervisors of the County of Orange.

(d) The governing body of the commission, subject to a two-thirds vote of the full membership, may increase the number of public members, or the number of members who are current Orange County Health Authority members or family members of current Orange County Health Authority members who may serve as a member of the governing body, subject to an affirmative vote by a majority of the Board of Supervisors of the County of Orange, provided, however, that a change in the composition of the governing body under this subdivision shall not result in the elimination of any member described in paragraph (1) of subdivision (a).

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(e) Each member of the governing body shall have the responsibility and duty to follow the requirements of applicable federal and state laws and regulations, including Section 1090 of the Government Code, the applicable provisions of Sections 87100 to 87500, inclusive, of the Government Code, and Section 14047.6 of this code, to serve the public interest of the members of the Orange County Health Authority, and to ensure the operational well-being and fiscal solvency of the Orange County Health Authority. Members of the governing body shall further strive to improve health care quality, promote prevention and wellness, ensure the provision of cost-effective health and behavioral health care services, reduce health disparities, address the needs of Medi-Cal members who are affected by homelessness and housing instability, improve quality outcomes, and manage the risk and needs of Medi-Cal beneficiaries through whole-person care approaches and addressing social determinants of health. The Orange County Health Authority shall work to earn the public's trust through its commitment to accountability, responsiveness, transparency, reliability, and cooperation.

(f) A member of the governing body who has a financial interest, within the meaning of Section 87100 of the Government Code, in a decision before the governing body shall, upon identifying a conflict of interest or a potential conflict of interest and immediately prior to the consideration of the matter, do all of the following:

(1) Publicly identify the financial interest that gives rise to the conflict of interest or potential conflict of interest in detail sufficient to be understood by the public, except that disclosure of the exact street address of a residence is not required.

(2) Recuse the member's own self from discussing and voting on the matter.

(3) Leave the room until after the discussion, vote, and any other disposition of the matter is concluded, unless the matter has been placed on the portion of the agenda reserved for uncontested matters.

(4) Notwithstanding paragraph (3), the member may speak on the issue during the time that the general public speaks on the issue.

(g) (1) A member of the governing body shall not, for a period of one year after leaving office, act as an agent or attorney for, or otherwise represent, for compensation, any other person, by making any formal or informal appearance before, or by making any oral or written communication to, the commission, or any committee, subcommittee, or present member of the commission, or any officer or employee of the commission, if the appearance or communication is made for the purpose of influencing administrative action or influencing any action or proceeding involving the issuance, amendment, awarding, or revocation of a permit, license, grant, or contract, or the sale or purchase of goods or property.

(2) In addition to paragraph (1), a member of the governing body described in subparagraphs (A) and (G) of paragraph (1) of subdivision (a) shall not, for a period of one year after leaving office, serve as an employee, agent, or attorney, or otherwise represent, for compensation, the Orange County Health Authority or any other entity that received an expenditure

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of Medi-Cal funds from the Orange County Health Authority during the prior five years. This paragraph does not apply to expenditures of Medi-Cal funds from the Orange County Health Authority for routine administrative expenses for reimbursement for travel, continuing education costs, routine office expenses, and other ongoing routine administrative expenses. This paragraph does not prevent any member from returning to or continuing the role that they held when they were appointed to the governing body.

SEC. 2. Section 14087.591 is added to the Welfare and Institutions Code, to read:

14087.591. (a) The governing body of the Orange County Health Authority shall authorize and pay for an independent external audit of the Orange County Health Authority's governance procedures and practices. The audit shall be conducted by an independent entity with demonstrated expertise in health care governance, board oversight, and managed care operations. The entity conducting the audit shall be announced at an Orange County Health Authority board meeting and opportunity for interested stakeholders to submit input to the entity for particular actions to be reviewed shall be permitted.

(b) The independent external audit shall evaluate, at a minimum, all of the following:

(1) The Orange County Health Authority's conflict-of-interest policies and procedures, including policies governing disclosures, recusals, and potential conflicts involving members of the governing body, officers, employees, and individuals participating in contracting or procurement decisions.

(2) The roles and responsibilities of the governing body, executive leadership, and staff to ensure appropriate separation between governance and oversight functions and the day-to-day operations and management of the Orange County Health Authority.

(3) The Orange County Health Authority's policies and practices governing contracting, procurement, and vendor selection to ensure decisions are made consistent with applicable laws, regulations, fiduciary obligations, and established governance practices. In reviewing the governing practices, the independent audit shall review particular actions identified by interested stakeholders as described in subdivision (a).

(4) The Orange County Health Care Agency's policy for nominating members to the governing body. The audit shall determine if the policy sufficiently prioritizes strategies to attract and retain professionals with a background in health care to be nominated to the board and provide suggestions on recruitment as necessary.

(5) Whether the Orange County Health Authority's governance structure, policies, or practices appropriately preserve the ability of executive leadership and staff to independently conduct contracting and procurement functions consistent with the governing body's oversight role.

(6) Recommendations to strengthen governance practices, accountability, transparency, and appropriate oversight by the governing body.

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(c) In order to evaluate the items in subdivision (b), the independent audit shall conduct interviews with staff of the Orange County Health Authority and provide anonymous opportunities to share feedback. All information provided by staff will be stripped of identifying information and staff will not be subject to professional discipline in retaliation for participating in the audit or for information they share in the audit process.

(d) The independent external audit shall be completed and the governing body shall submit the audit report to the Legislature and the department no later than July 1, 2027.

(1) The requirement for submitting a report imposed under this subdivision is inoperative on July 1, 2031, pursuant to Section 10231.5 of the Government Code.

(2) A report to be submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(e) The governing body of the Orange County Health Authority shall review the findings and recommendations of the independent external audit and develop a corrective action plan, as appropriate, to address any identified deficiencies.

(f) The Orange County Health Authority shall make the audit report and any corrective action plan available to the public, consistent with applicable confidentiality and proprietary information requirements.

SEC. 3. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances applicable to the County of Orange with respect to the operation and governance of the Orange County Health Authority, which is a county-organized health system known as CalOptima.

SEC. 4. The Legislature finds and declares that Section 2 of this act, which adds Section 14087.591 to the Welfare and Institutions Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to balance the public's right to access records with the need to protect proprietary information and interviewed staff of the Orange County Health Authority from retaliation, it is necessary that proprietary information and an interviewed staff's identity be kept confidential.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district are the result of a program for which legislative authority was requested by that local agency or school district, within the meaning of Section 17556 of the Government Code and Section 6 of Article XIII B of the California Constitution.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

18. Authorize Amendments to the CalOptima Health Ancillary Services Contracts with Community Supports Providers, the Orange County Health Care Agency, and Applicable Medi-Cal Shared Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Network Contracts for the Medi-Cal Program

Contacts

Ladan Khamseh, Interim Chief Operating Officer (714) 246-8866
Michael Gomez, Executive Director, Network Operations (714) 347-3292

Recommended Action

Authorize the Chief Executive Officer, or designee, to execute amendments to revise Enhanced Care Management payment rates and frequency of services, in accordance with Department of Health Care Services requirements, with CalOptima Health Community Supports providers, the Orange County Health Care Agency, and applicable Medi-Cal Shared Risk Group, Physician-Hospital Consortium, and Health Maintenance Organization health networks, effective December 1, 2026.

Background and Discussion

Staff requests authorization to amend CalOptima Health's Ancillary Services Contracts with Community Supports providers, the Orange County Health Care Agency (OCHCA), and applicable Medi-Cal Shared Risk Group (SRG), Physician-Hospital Consortium (PHC), and Health Maintenance Organization (HMO) Health Network Contracts to revise Enhanced Care Management (ECM) payment rates and frequency of services. Pending CalOptima Health Board of Directors' (Board) approval, the amendments will be effective December 1, 2026.

The requested approval to amend contracts will ensure CalOptima Health administers ECM program services in alignment with Department of Health Care Services (DHCS) updates and program requirements. In accordance with the DHCS ECM Policy Guide, the proposed amendments will reflect the following changes:

- Update the payment rates to apply a twenty percent (20%) decrease to the current ECM per member per month (PMPM) rate for eligible members receiving three (3) or more hours of ECM services in each month as identified by twelve (12) or more units.

Based on recent communication from DHCS to CalOptima Health, DHCS is focused on addressing and reducing inappropriate or low-value ECM utilization. To accomplish this, DHCS focuses on ensuring community-based, high-touch, person-centered services, strengthening eligibility and utilization management criteria and increasing reliance on encounter data for future risk-corridor settlements.

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Although there is no explicit fee schedule for ECM services, DHCS has compared the cost per hour of direct ECM services used in funding assumptions collected from managed care plan experiences. At times, DHCS has identified significant discrepancies. For this reason, the adjustments to reduce the ECM PMPM rate combined with an increase to the minimum floor of expected units will better align CalOptima Health's operations to DHCS's expectations. This improved alignment will ensure the ECM benefit remains fiscally viable for the foreseeable future.

Fiscal Impact

The recommended action to authorize contract amendments with updated payment rates and frequency of services is forecasted to reduce ECM expenses by approximately 20% (or $3.1 million) based on the Board-approved CalOptima Health Fiscal Year 2026-27 Operating Budget. The actual net impact may vary subject to the DHCS ECM risk corridor settlement process.

Rationale for Recommendation

Authorization of the amendments will align CalOptima Health's Ancillary Services Contracts with Community Supports providers, OCHCA, and applicable Medi-Cal SRG, PHC, and HMO Health Network Contracts for the provision of ECM services with current DHCS updates and ECM program requirements.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by the Recommended Action
2. Ancillary Services Contract/OCHCA Amendment Template
3. HMO/SRG/PHC-Physician Health Network Contract Amendment Template

Board Actions

Board Meeting Dates	Action
June 1, 2023	Authorize staff to amend the CalOptima Health Ancillary Services Contracts with Community Supports providers as follows: 1. Incorporate Enhanced Care Management (ECM) program services and modifications that align with updates in the Department of Health Care Services (DHCS) ECM Policy Guide, effective July 1, 2023; and 2. Implement new ECM provider case rates.

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Attachment to the November 5, 2026, Board of Directors Meeting – Agenda Item #18

CONTRACTED / IMPACTED ENTITIES COVERED BY THE RECOMMENDED ACTION

Name	Address	City	State	Zip Code
Abrazar, Inc.	7101 Wyoming Street	Westminster	CA	92683
AIDS Services Foundation Orange County dba Radiant Health Centers	17982 Sky Park Cir., Suite J	Irvine	CA	90614
AltaMed Health Network, Inc.	1401 N Montebello Blvd.	Montebello	CA	90640
American Family Housing	15161 Jackson Street	Midway City	CA	92655
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
Angelian Management Group LLC dba Laguna Adult Day Health Center	23551 Moulton Pkwy	Laguna Hills	CA	92653
Asian American Senior Citizens Service Center	850 N Birsch Street	Santa Ana	CA	92701
Boys & Girls Clubs of Garden Grove Inc	10540 Chapman Avenue	Garden Grove	CA	92840
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Casa De La Familia	1650 E 4th	Santa Ana	CA	92701
Celebrating Life Community Health Center	1444 S Main Street	Santa Ana	CA	92707
Central County Senior Services LLC	2515 McCabe Way Suite 200	Irvine	CA	92614
Child Guidance Center, Inc.	600 W Santa Ana Blvd. Suite 600	Santa Ana	CA	92701
Childrens Hospital of Los Angeles	4650 W Sunset Blvd., MS 87	Los Angeles	CA	90027
CHOC Physicians Network	1120 West La Veta Avenue Suite 450	Orange	CA	92868
Community Action Partnership of Orange County	11870 Monarch Street	Garden Grove	CA	92841

Information compiled by CalOptima Health staff on 10/26/2026

The list above only includes information that staff found through a search of publicly available information, and Directors should not solely rely on this list in determining whether a conflict of interest exists. Only a Director is aware of all their relevant interests under California law, and the California Fair Political Practices Commission ("**FPPC**") concluded that individual Directors are responsible for their own conflict determinations and advice (or lack of advice) from another party is not a defense for a violation. As such, this list is simply one tool that Directors may use in determining whether a conflict of interest exists. If a Director has a question about whether a specific interest is disqualifying, the Director should seek legal counsel to assist in making that determination.

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Name	Address	City	State	Zip Code
Community SeniorServ, Inc. dba Meals on Wheels OC	1200 Knollwood Circle	Anaheim	CA	920801
Council on Aging - Southern California	2 Executive Circle, Suite 175	Irvine	CA	92614
Dr. Patricia's Health Club, Inc.	1310 Stewart Drive	Orange	CA	92868
Epidaurus dba Amity Foundation	280 N Wilshire Avenue	Anaheim	CA	92801
Families Together of Orange County	661 W First Street, Suite G	Tustin	CA	92780
Five Acres The Boys' And Girls' Aid Society Of Los Angeles County dba Five Acres	867 N Fair Oaks Avenue	Pasadena	CA	91103
Friendship Shelter, Inc	24361 El Toro Rd., Suite 215	Laguna Woods	CA	92637
Global Transitional Care, Inc.	5161 California Avenue Suite 200	Irvine	CA	92617
Healthcare in Action Medical Group	3800 Kilroy Airport Way Suite 100	Long Beach	CA	90806
HealthRIGHT 360	3550 Camino Del Rio N Suite 320	San Diego	CA	92108
Heritage Health Network	2155 Chicago Avenue Suite 201	Riverside	CA	92507
Heritage Provider Network, Inc.	8511 Fallbrook Avenue Suite 350	West Hills	CA	91304
Housing For Health Orange County, Inc.	17701 Cowan Avenue Suite 200	Irvine	CA	92614
Human Options, Inc.	1300 E McFadden Avenue	Santa Ana	CA	92705
Hurtt Family Health Clinic, Inc.	14642 Newport Avenue Suite 200	Tustin	CA	92780
Illumination Health + Home	1091 N Batavia Street	Orange	CA	92867
JSI Acquisitions, Inc dba Libertana Home Health (of Sherman Oaks)	5805 Sepulveda Blvd. Suite 605	Can Nuys	CA	91411
Koinonia Foster Homes, Inc.	17821 E 17th Street Suite 240	Tusin	CA	92780

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Name	Address	City	State	Zip Code
Korean Community Services Inc. dba KCS Health Center	7212 Orangethorpe Avenue Suite 9A	Buena Park	CA	90621
Mariposa Women and Family Center	1845 W Orangewood Avenue Suite 300	Orange	CA	92868
Mindful Living Center California LLC	8295 Westminster Blvd.	Westminster	CA	92683
MOMS Orange County	1128 W Santa Ana Blvd.	Santa Ana	CA	92703
Monarch Health Plan, Inc.	1 Technology Drive	Irvine	CA	92618
North Orange County Regional Health Foundation	1182 N Euclid Street	Anaheim	CA	92801
Nurturing Care LLC	322 Culver Blvd. Suite 1151	Playa Del Rey	CA	90293
Olive Crest	2130 E 4th Street, Suite 107	Santa Ana	CA	92705
Orange County Asian and Pacific Islander Community Alliance, Inc.	12912 Brookhurst Street Suite 410	Garden Grove	CA	92840
Orange County Health Care Agency	405 W 5th Street	Santa Ana	CA	92701
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Avenue	Cypress	CA	90630
Pair Team Medical Group of California, PC.	95 3rd Street, Suite 293	San Fraancisco	CA	94103
PATH	340 N Madison Avenue	Los Angeles	CA	90004
Project Kinship	2215 N Broadway, Suite 2	Santa Ana	CA	92706
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
ReSolutionCare, PC	1875 S Grand Street, Suite 760	San Mateo	CA	94402
Rx Consultants Group, Inc.	2621 S Bristol Street Suite 100	Santa Ana	CA	92704
Seneca Family of Agencies	1801 Park Court Pl, Bldg H	Santa Ana	CA	92701
Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

Information compiled by CalOptima Health staff on 10/26/2026

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Name	Address	City	State	Zip Code
Share Our Selves Corporation	1550 Superior Avenue	Costa Mesa	CA	92627
South Coast Children's Society, Inc. dba South Coast Community Services	25910 Acero, Suite 160	Mission Viejo	CA	92691
Southland Integrated Services, Inc.	9862 Chapman Avenue	Garden Grove	CA	92841
Sowing Seeds Health, Inc.	2902 Irvine Center Drive Suite 105	Irvine	CA	92604
St. Jude Neighborhood Health Centers	731 S Highland Avenue	Fullerton	CA	92832
Sterling Hospitalist Medical Group, Inc. dba Titanium Healthcare	12566 Valley View Street	Garden Grove	CA	92845
United Care Medical Group, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
Vista Community Clinic dba VCC: The Gary Center	201 S Harbor Blvd.	La Habra	CA	900631
Western Youth Services	23461 South Pointe Drive Suite 220	Laguna Hills	CA	92653

Information compiled by CalOptima Health staff on 10/26/2026

The list above only includes information that staff found through a search of publicly available information, and Directors should not solely rely on this list in determining whether a conflict of interest exists. Only a Director is aware of all their relevant interests under California law, and the California Fair Political Practices Commission ("**FPPC**") concluded that individual Directors are responsible for their own conflict determinations and advice (or lack of advice) from another party is not a defense for a violation. As such, this list is simply one tool that Directors may use in determining whether a conflict of interest exists. If a Director has a question about whether a specific interest is disqualifying, the Director should seek legal counsel to assist in making that determination.

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AMENDMENT {X} TO
ANCILLARY SERVICES CONTRACT

This Amendment {X} to the Ancillary Services Contract ("**Amendment**") is effective as of **December 1, 2026** ("**Amendment Effective Date**") by and between the Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and {Provider Name} ("**Provider**"). CalOptima and Provider may each be referred to herein as a "Party" and collectively as the "Parties".

RECITALS

A. CalOptima and Provider have entered into an Ancillary Services Contract, originally effective {Original Contract Effective Date}, ("**Contract**"), by which Provider agrees to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Provider desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Section {3}, *ECM Services for Medi-Cal program*, in its entirety and replace it with the following new Section {3}, *ECM Services for Medi-Cal program*, to the Attachment {X}, *Compensation*:

3. ECM Services for Medi-Cal program

3.1 CalOptima shall pay Provider during the term of the Contract the ECM Supplemental Payment rate of ${XXX} PMPM for each Member who receives three (3) or more hours of ECM services in a given month as identified by twelve (12) or more units, subject to ECM Provider's compliance with all of the following conditions:

3.1.1 Member is identified as an ECM-eligible Member, as determined by CalOptima based on DHCS ECM eligibility criteria and in accordance with CalOptima Policy GG.1354;

3.1.2 Member is authorized by CalOptima to receive ECM services;

3.1.3 Member receives one or more of the ECM core service components (as set forth in Section {2.43} of the Contract and further outlined in Attachment {A}) in the prior month;

3.1.4 ECM Provider bills and reports ECM services to CalOptima consistent with CalOptima Policies, including CalOptima Policy FF.4002, and DHCS requirements; and

3.1.5 If applicable, ECM Provider authorized such ECM services and then ECM Provider paid in full the provider delegated and authorized by Provider to render the ECM services.

3.2 For purposes of Section 3.1., "**PMPM**" means an all-inclusive case rate that applies whenever Provider, as the ECM Provider, has provided the minimum level of service payable to an ECM Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

3.3 Prompt Payment. Upon validation of the ECM billing data, as applicable, and in accordance with CalOptima Policy FF.4002, CalOptima shall pay Provider the ECM Supplemental Payment for ninety (90) percent of ECM Members within thirty (30) calendar days of the date of receipt of the applicable billing data and for

DRAFT - Pending Board Approval

ninety-nine (99) percent of all ECM Members within ninety (90) calendar days of the date of receipt of the applicable billing data. The date of receipt shall be the date CalOptima receives the billing data. The date of payment shall be the date on the check or other form of payment. CalOptima's payments to Provider in time and manner shall comply with CalOptima Policies and applicable laws.

2. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

3. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROVIDER:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

DRAFT - Pending Board Approval

AMENDMENT {X} TO
CONTRACT FOR HEALTH CARE SERVICES

This Amendment {X} to the Contract for Health Care Services ("**Amendment**") is effective as of December 1, 2026 ("**Amendment Effective Date**") by and between the Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and {PROVIDER NAME} **("Physician/HMO").** CalOptima and Physician/HMO may each be referred to herein as a "Party" and collectively as the "Parties".

RECITALS

A. CalOptima and Physician/HMO have entered into a Contract for Health Care Services, originally {Original Contract Effective Date}, ("**Contract**"), by which Physician/HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician/HMO desire to amend the Contract on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Delete Attachment {E-8}, *Funding for Enhanced Care Management (ECM) Services*, in its entirety and replace it with new Attachment {E-8}, *Funding for Enhanced Care Management (ECM) Services,* attached to this Amendment and incorporated into the Contract.

2. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

3. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

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IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR Physician/HMO:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

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ATTACHMENT {E-8}

Funding for Enhanced Care Management (ECM) Services

CalOptima shall make an ECM Supplemental Payment to Physician/HMO for ECM services provided to an ECM Member, in accordance with the terms and conditions of CalOptima Policy FF.4002 and this Attachment.

1. ECM Services Supplemental Payment

   1.1 CalOptima shall pay Physician/HMO during the term of the Contract the ECM Supplemental Payment rate of ${XXX} Per Member Per Month ("**PMPM**") for each Member who receives three (3) or more hours of ECM services in a given month as identified by twelve (12) or more units, subject to Physician's/HMO's compliance with all of the following conditions:

   - Member is identified as an ECM-eligible Member, as determined by CalOptima based on DHCS ECM eligibility criteria and in accordance with CalOptima Policy GG.1354;
   - Member is authorized by CalOptima to receive ECM services;
   - Member receives one or more of the ECM core service components (as set forth in Section {6.23.9.4} of the Contract) in the prior month;
   - Physician/HMO bills and reports ECM services to CalOptima consistent with CalOptima Policies, including CalOptima Policy FF.4002 and DHCS requirements; and
   - If applicable, the Physician/HMO paid the provider delegated by Physician/HMO to render ECM services; and Physician/HMO authorized such ECM services.

2. For purposes of this Attachment {E-8}, "**PMPM**" means an all-inclusive case rate that applies whenever Physician/HMO, as the ECM Provider, has provided the minimum level of service payable to an ECM Member. This rate is paid on the basis of submitted claims and is not to be considered a capitation payment.

3. Prompt Payment. Upon validation of the ECM billing data, as applicable, and in accordance with CalOptima Policy FF.4002, CalOptima shall pay Physician/HMO the ECM Supplemental Payment for ninety (90) percent of ECM Members within thirty (30) calendar days of the date of receipt of the applicable billing data and for ninety-nine (99) percent of all ECM Members within ninety (90) calendar days of the date of receipt of the applicable billing data. The date of receipt shall be the date CalOptima receives the billing data. The date of payment shall be the date on the check or other form of payment. CalOptima's payments to Physician/HMO in time and manner shall comply with CalOptima Policies and applicable laws.

4. In addition to Section {9.4} of this Contract, Physician/HMO agrees to CalOptima's recovery of any overpayment of ECM Services Supplemental Payment in accordance with Policy FF .4002.

DRAFT - Pending Board Approval

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calender

19. Status Report on Enhanced Care Management Benefit for Medi-Cal Members

Contact

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Action

Accept, receive, and file a Status Report on Enhanced Care Management benefit for Medi-Cal Members.

Background

At the October 1, 2026, Regular meeting of the CalOptima Health Board of Directors, in response to public comments made by community-based organizations (CBOs), Chair Vicente Sarmiento directed staff to agendize an item for the Board to discuss. As such, staff is bringing forth an update for Enhanced Care Management (ECM).

ECM

California Advancing and Innovating Medi-Cal (CalAIM) is an initiative of the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal members by implementing delivery system, program, and payment reforms across the Medi-Cal program. A key feature of CalAIM is the statewide introduction of the ECM managed care benefit . MCPs are responsible for administering ECM in close collaboration with their network of community-based providers.

As defined by DHCS, ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch, and person centered. DHCS's vision for ECM is to coordinate all care for members who receive it, including across the physical and behavioral health delivery systems. ECM is a statewide Medi-Cal managed care benefit.

In 2021, DHCS required each MCP, including CalOptima Health, to develop and submit an ECM Model of Care (MOC) for DHCS approval in preparation to go-live with ECM in 2022. The MOC is each MCP's detailed plan for providing ECM in accordance with DHCS' requirements.

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Each MCP's MOC includes:

- Overall approach to ECM
- Detailed policies and procedures for partnering with Providers, including non-traditional Medi-Cal providers and those who are outside of the MCP networks, but provide relevant services to ECM-eligible members, for the administration of ECM
- ECM provider capacity; and
- MCP policies and procedures that will define its arrangements with its ECM t providers.

ECM is a data-driven program. As such, DHCS performs a thorough and regular review of inbound MCP data submitted via the monthly implementation monitoring reports. DHCS expects MCPs to regularly perform oversight and robust benefit management of ECM to ensure delivery of services with fidelity to the guidance presented in the ECM Policy Guide (Attachment 1), and to maintain program integrity and quality.

- The requirement for MCPs to implement ECM derives from the MCP Contract, DHCS All Plan Letter 23-032, and DHCS ECM Standard Provider Terms and Conditions.

DHCS established nine (9) Populations of Focus (PoF) in 2021 and updated the PoFs in 2026. The current ECM PoFs include:

1) Individuals and Families Experiencing Homelessness
2) Individuals At Risk for Avoidable Hospital or Emergency Department Utilization (High Utilizers)
3) Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
4) Individuals Transitioning from Incarceration (Justice-Involved)
5) Adults Living in the Community and At Risk for Long-Term Care Institutionalization
6) Adult Nursing Facility Residents Transitioning to the Community
7) Children and Youth Enrolled in California Children Services (CCS) or CCS Whole Child Model with Additional Needs Beyond the CCS Condition
8) Children and Youth Involved in Child Welfare
9) Birth Equity PoF

Each PoF includes a detailed definition for the PoF with eligibility criteria, examples of eligible members, and operational guidance to support implementation. MCPs must use the eligibility criteria provided to evaluate members and may not impose additional eligibility requirements for authorization of ECM.

Please note, race or ethnicity alone are not separate and distinct PoFs as identified by DHCS.

Discussion

Since 2022, CalOptima Health has provided the training, education, and ongoing technical support necessary to help providers deliver high-quality, trauma-informed, culturally responsive, and person-centered ECM services.

CalOptima Health developed and launched the ECM Academy in January 2023 to train and onboard CBOs to become contracted ECM providers. The ECM Academy is a six-month program, which consists of (i) weekly training related to DHCS policy requirements, (ii) the seven (7) core components of ECM, and (iii) best practices for providing services to the PoFs. Since January 2023, CalOptima Health has held three (3) ECM Academies graduating 61 ECM providers.

The ECM network is comprised of:

- 54% CBOs;
- 25% Community Health Centers;
- 8% Health Networks;
- 5% Primary Care Providers or Hospitals; and
- 8% Other (Street Medicine Provider, Adult Day Health Center, etc.).

Each contracted organization serves at least one (1) PoF, ensuring broad coverage and access to specialized services across every PoF category. This diverse network allows CalOptima Health to connect members with providers that understand their unique needs, communities, and barriers to care. To date, 21,629 unique members have received ECM services, representing 2.7% of the current membership, and exceeding DHCS's goal of 1% for MCPs. In Fiscal Year 2025-26, CalOptima Health's total expenditure on ECM services was $36.1 million.

Addressing Concerns around Cultural Competency and Language Access

CalOptima Health's ECM program is designed to effectively address the diverse needs of the various PoFs specified by DHCS. At the launch of the benefit, CalOptima Health developed a prioritization algorithm that considers clinical complexity, social determinants of health, and individual member needs to ensure that CalOptima Health connects qualifying members to providers with the most appropriate competencies.

This targeted approach accommodates the unique requirements of vulnerable groups, including those with chronic conditions, individuals experiencing homelessness, and members with significant behavioral health challenges. Through careful alignment with DHCS criteria, CalOptima Health's ECM algorithm not only enhances care coordination, but also promotes equitable access to essential services, ultimately fostering better health outcomes for all members.

While the algorithm recognizes the significance of cultural context and effective communication in fostering trust and engagement with members, it firmly prioritizes clinical factors such as the severity of health conditions, medical history, and the complexity of care needs. This strategic emphasis ensures that, although cultural sensitivity and language proficiency are integral to the member-provider relationship, they serve as complementary elements rather than overriding criteria. By grounding its ECM services in robust clinical assessments, CalOptima Health aims to connect members with providers who not only understand their cultural backgrounds but also possess the requisite expertise to address their health challenges effectively. In this way, the algorithm promotes a holistic approach that enhances care coordination and improves health outcomes while respecting and acknowledging the diverse identities and experiences of its members.

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Fiscal Impact

The recommended action has no fiscal impact.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. ECM Policy Guide
2. Background on ECM Program Summary

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CALAIM ENHANCED CARE MANAGEMENT POLICY GUIDE

Updated September 2026

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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I. INTRODUCTION

This California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) Policy Guide is intended to serve as a resource for Medi-Cal Managed Care Plans (MCPs) in the implementation of ECM. The Policy Guide provides a comprehensive overview of ECM as well as additional operational guidance for MCPs.

CalAIM is an initiative of the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Members by implementing delivery system, program, and payment reforms across the Medi-Cal program. A key feature of CalAIM is the statewide introduction of the ECM managed care benefit and a menu of Community Supports, which, at the option of an MCP and a Member, can substitute for covered Medi-Cal services as cost-effective alternative services. MCPs are responsible for administering both ECM and Community Supports in close collaboration with their network of community-based Providers. DHCS expects MCPs to prioritize contracting with locally-based providers who address equity gaps and are culturally responsive to their community to the extent they meet the required capabilities for delivering ECM benefits.

ECM and Community Supports have been developed from lessons learned, as well as MCP and Provider experience, in the Whole Person Care (WPC) Pilots and Health Homes Program (HHP). Both WPC and HHP led the way in providing a set of intensive care coordination services that spanned multiple delivery systems to provide a person-centered approach to care. These initiatives also pushed the boundaries of a traditional health care delivery approach to begin formally considering the impact of social drivers of health (SDOH) on health outcomes and experience of care in Medi-Cal.[1]

DHCS' adoption of ECM and Community Supports on a statewide scale supports the highest-need Medi-Cal MCP Members. ECM and Community Supports are anchored in the community, where services can be delivered in an in-person manner by community- based ECM and Community Supports Providers, to the greatest extent possible. While ECM and Community Supports may both be appropriate for certain

[1] Refer to the All Plan Letter (APL) 21-009 (Revised) or superseding APL for more information.

Members, they are separate initiatives, and some Medi-Cal Members will qualify for only ECM or only Community Supports. For detailed information about Community Supports, please refer to the separate Community Supports Policy Guide, Volume I and Volume II.

ECM is an integral component of DHCS' Population Health Management (PHM) Program under CalAIM. The PHM Program is designed to ensure that all Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, ranging from wellness and prevention to ECM for those with the highest health and social needs. For more on the PHM Program, see the PHM Policy Guide and DHCS' PHM webpage.

Each MCP is required to develop and submit for DHCS approval an ECM and Community Supports Model of Care (MOC). The MOC is each MCP's detailed plan for providing ECM and Community Supports in accordance with DHCS' requirements. Each MCP's MOC includes its overall approach to ECM and Community Supports; its detailed policies and procedures for partnering with Providers, including non-traditional Medi- Cal Providers and those who are outside of the MCP networks but provide relevant services to ECM-eligible Members, for the administration of ECM and Community Supports; its ECM and Community Supports Provider capacity; and the MCP Policies and Procedures that will define its arrangements with its ECM and Community Supports Providers. Starting in 2023, the MOC should also include information about how the MCP is identifying and internally tracking key performance indicators for successful growth of ECM, such as the volume of referrals from providers and others, and self and family referrals. Part of the purpose of this tracking is to ensure that the majority of ECM referrals originate from community-based sources.

DHCS is committed to data-driven oversight of ECM and expects MCPs to have a data- driven approach to their implementation and monitoring of ECM. To meet this objective, DHCS is doing a thorough and regular review of inbound MCP data submitted via the monthly JSON file submission and will be analyzing ECM encounter data, when fully available. DHCS expects MCPs to regularly perform oversight and robust benefit management of ECM to ensure delivery of services with fidelity to the guidance presented in this Policy Guide, and to maintain program integrity and quality. Consistent communication with partners and stakeholders is also key to DHCS' plans for monitoring, targeting technical assistance, and modifying program policies and procedures. DHCS is in continuous communication with MCPs, Providers, and other stakeholders whose work intersects with ECM, through the PHM Advisory

Group, CalAIM Implementation Advisory Group, and other forums for stakeholder feedback on implementation.

The requirement for MCPs to implement ECM is derived from the MCP Contract, the ECM APL (APL 21-012) or superseding APL, and DHCS' ECM and Community Supports Standard Provider Terms and Conditions. This Policy Guide is intended to serve as a comprehensive resource for MCPs administering ECM, as well as for other key stakeholders involved in ECM, including Providers, counties, and community-based organizations (CBOs).

Updates will be published as needed and posted on DHCS' ECM and Community Supports webpage, where stakeholders can also find other resources. MCPs and other stakeholders may direct their questions to DHCS using the following email address: EnhancedCareManagement@dhcs.ca.gov.

II. WHAT IS ENHANCED CARE MANAGEMENT (ECM)?

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems. ECM is a statewide Medi-Cal managed care benefit that was being phased in according to the schedule given in Section III below.

DHCS has long understood that the need for care management and coordination increases with clinical and social complexity and has worked for several years to build capacity for a more comprehensive approach to care management and coordination in Medi-Cal. In 2016, DHCS launched the WPC Pilots as part of its Medi-Cal 2020 1115 waiver. WPC Pilots tested interventions to coordinate physical, behavioral and social services in a patient-centered manner, including interventions that address SDOH such as improving access to housing and supportive services, and have built significant infrastructure to ensure local collaboration for improved outcomes. In 2018, DHCS launched the Health Homes Program (HHP). HHP served eligible Medi-Cal Members with complex medical needs and chronic conditions and coordinated the full range of

physical health, behavioral health and community- based long-term services and supports (LTSS).

ECM builds on both the design and the learning from the WPC Pilots and HHP. ECM, with Community Supports, replaces both initiatives, scaling up the interventions to form a statewide care management approach that is a key component of the overall PHM Program.

ECM offers comprehensive, whole person care management to high- need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

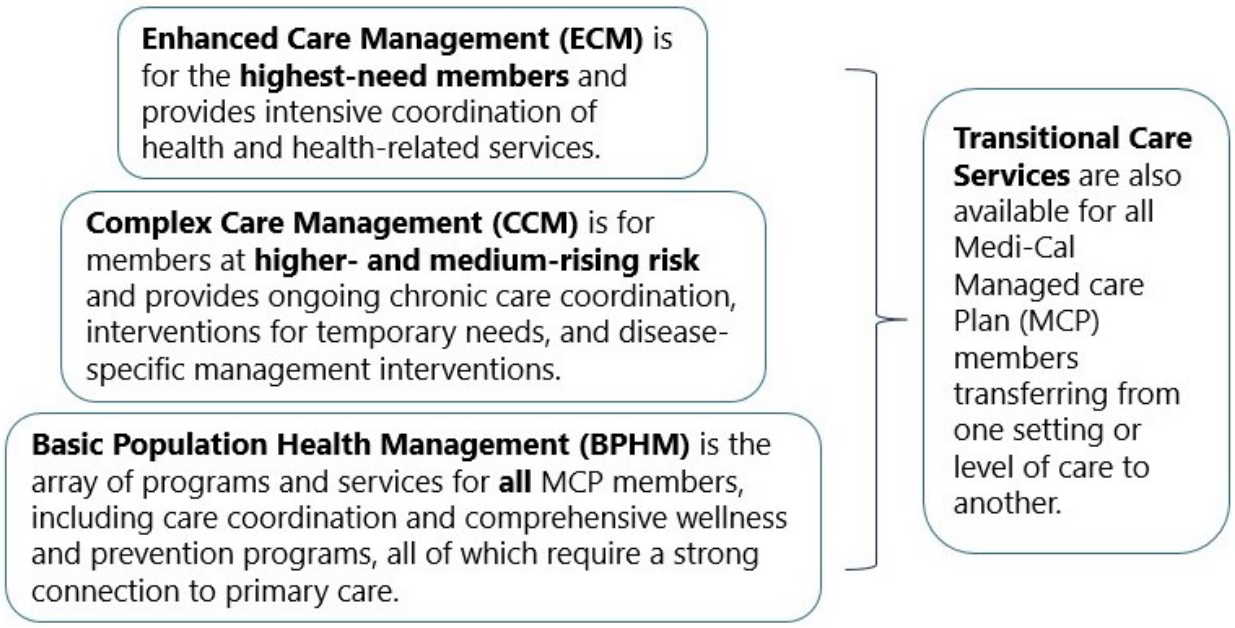
A. ECM and the PHM Program

On January 1, 2023, DHCS launched a new, comprehensive **Population Health Management (PHM) Program** as part of CalAIM. ECM is one component of that overarching program. Under the PHM Program, MCPs and their Network Providers and partners (such as local health jurisdictions and county welfare agencies) are to work together to be responsive to individual Member needs within the communities they serve while working within a common framework and expectations. The PHM Program is designed to ensure that all Medi-Cal managed care Members have access to a comprehensive set of services based on their needs and preferences across the continuum of care, with ECM intended for Members with the highest needs on that CalAIM Care Management Continuum. Two other care management programs exist within the Continuum, including Complex Care Management (CCM) for higher- and medium-rising risk Members and Basic Population Health Management (BPHM) for all Members. See Figure 1 below outlining the CalAIM Care Management Continuum and the PHM Policy Guide for more information.

DHCS is also building **Medi-Cal Connect**, a statewide data analytics solution and tool for population health management including ECM. When fully operational, Medi-Cal

Connect will provide MCPs, Providers, counties, Members, and other authorized users with access to comprehensive data on Members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, and social service data and other program information. Medi-Cal Connect will use these data to support risk stratification, segmentation and tiering, assessment and screening processes, and analytics and reporting functions. Medi-Cal Connect will also improve data accuracy and timeliness by providing members with the ability to update their information and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions and strengthen oversight. For more information about PHM, refer to the PHM Policy Guide and DHCS' PHM webpage.

Figure 1: CalAIM Care Management Continuum



III. ECM IMPLEMENTATION TIMELINE

Below is the most up to date ECM Implementation Timeline. Notice to MCPs and stakeholders will be provided in the event the timeline is modified. For more information, visit DHCS' ECM and Community Supports webpage.

Go Live Timing	Populations of Focus[2] [3]
January 1, 2022 *(Counties that participated in WPC, HHP or both)*	» Adults and their Families Experiencing Homelessness[4] » Adults At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (formerly "High Utilizers") » Adults with Serious Mental Health and/or Substance Use Disorder (SUD) Needs » Individuals Transitioning from Incarceration (some WPC counties)
July 1, 2022 *(Counties that participated in neither WPC nor HHP)*	» Adults and their Families Experiencing Homelessness » Adults At Risk for Avoidable Hospital or ED Utilization

[2] ECM has been available for adults with intellectual or developmental disabilities (I/DD) from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. In July 2023, children and youth with I/DD will also be eligible for ECM if they meet the eligibility criteria for any existing Population of Focus. See Section VI. Program Overlaps and Exclusions for more details about individuals with I/DD receiving Regional Center services.

[3] CM has been available to pregnant and postpartum adults from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. In July 2023, youth who are pregnant or postpartum will also be eligible for ECM if they meet the eligibility criteria for any existing Population of Focus.

[4] In the period between January 2022 and July 2023, ECM is available to adults and their dependent children experiencing homelessness. With the launch of ECM for children and youth, the definition will expand for children, youth, and families.

Go Live Timing	Populations of Focus[2] [3]
	» Adults with Serious Mental Health and/or SUD Needs
January 1, 2023 *(Statewide)*	» Adults Living in the Community and At Risk for Long Term Care (LTC) Institutionalization » Adult Nursing Facility Residents Transitioning to the Community
July 1, 2023 *(Statewide)*	» Children and Youth Populations of Focus • Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness • Children and Youth At Risk for Avoidable Hospital or ED Utilization • Children and Youth with Serious Mental Health and/or SUD Needs • Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition • Children and Youth Involved in Child Welfare
January 1, 2024 *(Statewide)*	» Birth Equity Population of Focus » Individuals Transitioning from Incarceration[5] (statewide, inclusive of the former WPC counties that already went live on January 1, 2022)

[5] In January 2023, the CalAIM 1115 justice initiative waiver request was approved by the Centers for Medicare and Medicaid Services (CMS).

IV. ECM POPULATIONS OF FOCUS (UPDATED JANUARY 2026)

To be eligible for ECM, Members must be enrolled in a Medi-Cal Managed Care Plan[6] and meet at least one of the ECM Populations of Focus definitions described below:

Sr No.	ECM Populations of Focus	Adults	Children & Youth
1a	Individuals Experiencing Homelessness: *Adults without Dependent Children/Youth Living with Them Experiencing Homelessness*	X	
1b	Individuals Experiencing Homelessness: *Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness*	X	X
2	Individuals At Risk for Avoidable Hospital or ED Utilization (*Formerly "High Utilizers"*)	X	X
3	Individuals with Serious Mental Health and/or SUD Needs	X	X
4	Individuals Transitioning from Incarceration	X	X
5	Adults Living in the Community and At Risk for LTC Institutionalization	X	
6	Adult Nursing Facility Residents Transitioning to the Community	X	
7	Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition		X
8	Children and Youth Involved in Child Welfare[7]		X
9	Birth Equity Population of Focus	X	X

[6] Medi-Cal recipients with a Share of Cost, excluding long-term care share of cost, are excluded from managed care and are thus not eligible for ECM.

[7] The population from age 21 to age 26 is likely a smaller population and DHCS does not report ECM data as 'Adult -Child Welfare POF'

A. Detailed Population of Focus Definitions (Updated January 2026)

The Populations of Focus definitions given below supersede the definitions originally described in the CalAIM Proposal of January 2021. Each Population of Focus includes a detailed definition for the Population of Focus with eligibility criteria; examples of eligible Members; and operational guidance to support implementation. MCPs must use the eligibility criteria provided to evaluate Members and **may not impose additional eligibility requirements for authorization of ECM**. For example, an MCP may not require that the ECM provider have a certain number of contacts with the Member as a condition of authorization. In the Populations of Focus definitions, "**adult**" is defined as an individual who is 21 years of age or older, and a "**child or youth**" is defined as an individual under 21. Consequently, the Children and Youth-specific definitions for ECM apply up to age 21, with limited exceptions as called out below for youth with a history of involvement with the child welfare system. When a Member under 21 is served in ECM and does not meet the adult ECM criteria upon turning 21, the Member should not be disenrolled from ECM due to aging out alone; rather, the ECM Provider and MCP should apply the MCP's usual, DHCS-approved "graduation" criteria to determine when the Member is ready to disenroll.

1. Individuals and Families Experiencing Homelessness

Individuals and families experiencing homelessness are among the highest-need and most vulnerable individuals in Medi-Cal, in that they lack access to shelter and food, both of which are critical to health. These individuals often have extensive medical and behavioral health needs that are difficult to manage due to the social factors that influence their health. This can result in reduced quality of life and high utilization of avoidable, costly services in EDs and inpatient settings that could be avoided with more timely and appropriate care management and potentially the provision of Community Supports. ECM provides the needed link between physical and behavioral health care and connection to housing and other resources associated with Social Drivers of Health (SDoH). In addition, communities of color are disproportionately impacted by homelessness in California and nationally, making ECM for this Population of Focus a critical tool in achieving racial health equity.

i. Population of Focus Eligibility Criteria (Updated January 2026):

This Population of Focus went live for homeless adults and families with the launch of ECM in 2022. Eligibility criteria was broadened to include unaccompanied children and youth, as well as whole families, with the launch of ECM for children and youth in July 2023, as laid out below. [8]

Eligibility Criteria Applicable from January 2026 and Onwards

a. Adults (whether or not they have dependent children/youth living with them) who:

(1) Are experiencing homelessness, defined as meeting one or more of the following conditions[9]:

(i) Lacking a fixed, regular, and adequate nighttime residence;

(ii) Having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(iii) Living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(iv) Exiting an institution into homelessness (regardless of length of stay in the institution);

(v) Will imminently lose housing in next 30 days;

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[8] From 2022 until June 30, 2023, children and youth were eligible only as part of a family unit with a qualifying adult meeting the Individuals Experiencing Homelessness POF definition.

[9] This definition of homelessness is based on the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 - General definition of homeless individual with the modification to Clause (v) timeframe for an individual who will imminently lose housing has been extended from 14 days (HHS definition) to 30 days. The wording of this definition has also been slightly modified for clarity, relative to the originally released definition.

(vi) Fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence;

AND

(2) Have at least one complex physical, behavioral, or developmental need, with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes **and/or** decreased utilization of high- cost services.[10]

OR

(3) Members authorized for Transitional Rent[11]

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

As of July 2023, the ECM eligibility criteria for this Population of Focus also includes children and youth, as shown below. The purpose of these modifications is to ensure that ECM captures the breadth of unsafe, substandard, and insecure living conditions that families, children, and youth may experience. To do this, the Population of Focus eligibility criteria are modified for children and youth from 45 CFR 11431a McKinney- Vento Homeless Assistance Act's definition of "at risk of homelessness." The California Department of Education (CDE) uses a similar definition of homelessness to identify students in need of housing support. DHCS continues to strengthen partnerships with CDE, such as the requirement for MCPs and Local Educational Agencies (LEAs) to enter into memoranda of understanding (MOUs) per the upcoming Medi-Cal Managed Care contract procurement going live in January 2024.

b. Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness

[10] Pregnant and postpartum individuals who are homeless are considered to have met this definition.

[11] Refer to the Community Supports Policy Guide (Volume II) for further Transitional Rent policy guidance.

(In Effect July 1, 2023, and Onwards)

Children, Youth, and Families with members under 21 years of age who:

(1) Are experiencing homelessness, as defined above in (a) under the modified HHS 42 CFR Section 11302 "Homeless" definition;

OR

(2) Sharing the housing of other persons (i.e., couch surfing) due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or abandoned in hospitals (in hospital without a safe place to be discharged to to), as modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act definition of "at risk of homelessness" [12]

OR

(3) Members authorized for Transitional Rent [13]

Notes on the (b) Definition:

- Children, youth, and families do not need to meet the additional "complex physical, behavioral, or developmental need" criteria noted above in Clause (2) for adults in (a).
- Clause (2) for children, youth, and families in (b) is modified from the 45 CFR 11434a McKinney-Vento Homeless Assistance Act definition of "at risk of homelessness" [14] and is included in this Population of Focus to ensure ECM captures the breadth of unsafe, substandard, and insecure living conditions that Members, particularly children and youth, may experience.

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

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[12] See McKinney-Vento Homeless Assistance Act

[13] Refer to the Community Supports Policy Guide (Volume II) for further Transitional Rent policy guidance.

[14] See McKinney-Vento Homeless Assistance Act

ii. Examples of Eligible MCP Members Under this Population of Focus (Updated January 2026):

- Member over age 21 experiencing homelessness who has complex health care needs as a result of unmanaged medical, psychiatric, or SUD-related conditions.
- Member with complex health care needs as a result of medical, psychiatric or SUD-related condition, who have recently received an eviction notice and will imminently lose housing in the next 30 days.
- Youth who has been excluded from home due to their gender identity or sexual orientation and is now temporarily living with the family of a friend (e.g., couch surfing).
- Parent and child who are fleeing domestic violence from a spouse at home.
- A pregnant person or person within 12 months postpartum experiencing homelessness.

iii. Operational Guidance:

Identification:

- As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow Network Providers to refer Members to the MCP for ECM if they suspect eligibility criteria are met and track key performance indicators to monitor and improve the volume of provider referrals.
- Engagement in ECM for this population may include street outreach or coordinating with shelters, Homeless Services Providers, Recuperative Care Providers, Community Partners (e.g., Homeless Coordinated Entry Systems) and other service Providers with experience working with homeless individuals and families.
    - Members and their families may self-refer to ECM.
    - MCPs are expected to utilize data from their regional Continuum of Care Homeless Management Information System (HMIS) to determine which of their members are experiencing homelessness and should be referred for ECM.

Outreach and Engagement (Updated January 2026):

As is true for all ECM Lead Care Managers, ECM requires engagement with the Member in the community or at Provider locations. Street medicine provides an opportunity to provide care to individuals who are experiencing homelessness by

meeting them where they are. Separately from ECM, DHCS issued a Street Medicine All Plan letter 24-001 to clarify how street medicine providers may utilize Presumptive Eligibility in mobile clinics, street teams or other locations to be able to provide immediate access to Medi-Cal Services. Street medicine providers may be ideally suited to conduct outreach and engage with Members who are experiencing homelessness, whether serving as ECM Lead Care Managers within their own teams or handing off to other ECM Providers who will take on the longitudinal role.

MCPs are strongly encouraged to conduct outreach to Members potentially eligible for ECM within family homeless shelters and coordinate with homeless outreach teams and other entities where families are known to be experiencing or at risk of homelessness. Examples of these entities may include local housing and homelessness programs serving families or pregnant or postpartum people, Head Start, schools, local WIC agencies, diaper banks, food banks, county First 5s, and CBOs supporting pregnant and postpartum people or families experiencing intimate partner violence.

Comprehensive Assessment and Care Management Plan:

For this Population of Focus, the Comprehensive Assessment and Care Management Plan should specifically address housing needs, in addition to any medical and/or social needs identified, and appropriate interventions to address these for the ECM Lead Care Manager to help connect the Member to sources of housing support, including (but not limited to) the pre-approved Community Supports. MCPs should ensure that ECM Providers serving members of this Population of Focus have detailed and up to date information about how to refer Members to housing Community Supports, including eligibility criteria and the operation of lifetime limits, where applicable.

Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process; [15] should consider and reflect what is important to the Member regarding their preferences for the delivery of LTSS (for example, specific treatment goals, services or functional needs the Member prefers to prioritize).

[15] As established in 42 CFR § 438.208 and 42 CFR § 441.301.

Examples of Applicable ECM Services for this Population of Focus (Updated January 2026):

For this Population of Focus, ECM should include addressing barriers to housing stability by connecting Members and their families to housing, health and social support resources. Examples of applicable services for this Population of Focus to be included in ECM include (but are not limited to):

- Facilitating access to housing-related Community Supports to identify housing and preparing individuals to secure and/or maintain stable housing, including housing that meets the unique needs of pregnant and postpartum individuals and families.
- Maintaining regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs and swiftly addressing any gaps to ensure progress toward regaining health and function.
- Coordinating and collaborating with various health and social services providers, including Regional Centers and county First 5s,[16] including sharing data (as appropriate) to facilitate better-coordinated whole-person care.
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Utilizing best practices such as Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.
- For homeless families, MCPs are strongly encouraged to work with ECM Providers to serve the family unit together through one ECM team, whenever possible and appropriate.

[16] **County First 5s** are local, county-based entities in each of California's 58 counties to provide essential resources and services at the local level to support child development, care, and education of children up to age five. Please visit the First 5 webpage for additional information.

Community Supports (Updated January 2026): MCPs are strongly encouraged to offer the housing- related Community Supports to Members who enroll in ECM under this Population of Focus.[17]

- Transitional Rent provides up to six months of rental assistance in interim and permanent settings. When the MCP authorizes a Member for Transitional Rent, it must also authorize the Member for ECM. The MCP is required to ensure that the ECM Provider conducts weekly in-person outreach visits to the Member.[18] Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services provide support to achieve long-term housing.
- (Housing Trio) Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services provide support to achieve long-term housing.
- Recuperative Care (Medical Respite) and Short-Term Post-Hospitalization Housing provide recovery-focused housing. Short-Term Post-Hospitalization Housing sunsets December 31, 2026
- Medically Tailored Meals/Medically-Supportive Food, Day Habilitation Programs, or Sobering Centers may also address the needs of this Population of Focus, depending on individual circumstances.

Provider Contracting (Updated January 2026):

- MCPs must contract with ECM providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities to serve as ECM Providers. As suggested above, MCPs are encouraged to contract with street medicine providers and other organizations specializing in serving individuals experiencing homelessness to serve as ECM Providers, provided they meet all other ECM Provider requirements. MCPs are also encouraged to contract with housing providers that meet

[17] For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the Community Supports Policy Guide, Volume I (non-housing) and Volume II (housing).

[18] Refer to the Community Supports Policy Guide (Volume II) for further Transitional Rent policy guidance on automatic ECM authorization, guidance on ECM Provider outreach, and implementation timeline.

the needs of individuals from pregnancy through 12 months postpartum, including with family shelters, to ensure the individual has a safe place to live during pregnancy and through 12 months postpartum. Please refer to Section VII. ECM Provider Network below for more information.

- MCPs may develop specific payment models (e.g., bundled rates) to reimburse ECM Providers for ECM delivered to a family.

2. Individuals At Risk for Avoidable Hospital or Emergency Department (ED) Utilization

In 2022, DHCS renamed the "High Utilizers" ECM Population of Focus to "Individuals At Risk for Avoidable Hospital or Emergency Department (ED) Utilization," to reflect that ECM for this Population of Focus aims to reduce avoidable care in costly settings and settings that are of higher acuity than would be necessary with earlier and more whole-person care interventions and approaches.

i. Population of Focus Eligibility Criteria:

a. Adults At Risk for Avoidable Hospital or ED Utilization

Adults who meet one or more of the following conditions:

(1) **Five or more** emergency room visits in a **six-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence;[19]

(2) **Three or more** unplanned hospital and/or short-term skilled nursing facility (SNF) stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

No further criteria are required to be met to qualify for this ECM population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

For this POF, MCPs may choose to authorize ECM for individuals who are at risk for avoidable hospital or ED utilization and who would benefit from ECM but who may not meet the numerical thresholds specified above. This flexibility is

[19] Including appropriate timing, interventions within outpatient care settings, care plan development, communication with the Member, interdisciplinary care team, or referrals.

in addition to and does not displace the numerical thresholds provided in the eligibility criteria.

b. Children and Youth At Risk for Avoidable Hospital or ED Utilization

Children and Youth who meet one or more of the following conditions:

(1) **Three or more** ED visits in a **12-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence; [20]

(2) **Two or more** unplanned hospital and/or short-term SNF stays in a **12-month** period that could have been avoided with appropriate outpatient care or improved treatment adherence.

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

For this POF, MCPs may choose to authorize ECM for individuals who are at risk for avoidable hospital or ED utilization and who would benefit from ECM but who may not meet the numerical thresholds specified above. This flexibility is in addition to and does not displace the numerical thresholds provided in the eligibility criteria.

ii. Examples of Eligible MCP Members under this Population of Focus:

- An adult with repeated incidents of avoidable ED visits in a six-month period who has a medical, psychiatric or SUD-related condition requiring intensive coordination beyond telephonic intervention.
- An adult with repeated incidents of avoidable ED visits in a six-month period who has significant functional limitations and/or adverse SDOH that impede them from navigating their health care and other services.
- A child with repeated incidents of ED visits in a 12-month period to address untreated asthma that could have been avoided with improved inhaler and nebulizer treatment.
- Siblings and their adult parent(s) with repeated incidents of avoidable ED visits in a 12-month period due to unsafe housing conditions and/or other adverse

[20] Including appropriate timing, interventions within outpatient care settings, care plan development, communication with the Member, interdisciplinary care team, or referrals.

SDOH that impede their caregiver from navigating their health care and other services. In this example, ECM could be provided to the family as a whole.

- Youth with repeated avoidable inpatient hospitalizations in a 12-month period due to a behavioral health condition.

iii. Operational Guidance:

Identification:

- MCPs must use the numerical thresholds described in eligibility criteria (a) and (b) above to identify Members in this Population of Focus. MCPs should have a consistent approach (e.g. algorithms or other methodologies) for identifying eligible Members.
- MCPs should utilize a "rolling" lookback period based on the most recent month of adjudicated claims data. Effective January 1, 2023, when all MCPs are expected to use Admission, Discharge, Transfer (ADT) feed data, whenever available, across their PHM Programs, MCPs should use ADT feed data to identify members potentially eligible for ECM in a timelier fashion.
- ED visits that result in an inpatient stay should only count as one inpatient visit.
- This flexibility is in addition to and does not displace the numerical thresholds provided in the eligibility criteria.
- Members and their families may self-refer to ECM.
- MCPs are currently required to report Ambulatory Care: Emergency Department Visits (AMB-CH) (a National Committee for Quality Assurance (NCQA) metric required in CMS' 2023 and 2024 Child Core Set Measures) and should align efforts to identify and serve this ECM Population of Focus with improvement on these metrics.

Outreach and Engagement:

Under PHM requirements, by January 1, 2023, MCPs are responsible for knowing when all Members are admitted, discharged or transferred and must assign a single point of contact/care manager to ensure all transitional care services are complete for all high risk Members, as defined in the PHM Policy Guide. MCPs are responsible for ensuring that ECM Providers have access to or are provided ADT feed data information for enrolled Members to allow them to manage transitions as part of ECM.

As is true for all ECM Lead Care Managers, ECM requires face-to-face engagement with the Member in the community or at Provider locations. ECM Providers may choose to embed staff directly within EDs to identify Members who are eligible for this

Population of Focus and coordinate closely with ED staff. MCPs may also or alternatively embed their own staff to perform the same function and hand off to an ECM Provider for further assessment.

Comprehensive Assessment and Care Management Plan:

The assessment and care planning process should identify the drivers of the ED or inpatient episodes in detail, which may extend beyond conditions into specific social needs. Since repeat ED utilization is often a result of lack of access to usual care, special attention should be given (including research with the MCP, as needed) to the Member's primary care provider (PCP) and connection to that PCP, or selection of a different PCP. Similarly, any gaps in access to specialists that may have driven the admission should be carefully assessed and addressed with the MCP. As part of its monitoring and oversight of ECM, DHCS will be reviewing medical conditions/diagnoses associated with avoidable ED utilization within members of this Population of Focus.

Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, as noted above under Population of Focus 1.

Examples of Applicable ECM Services for this Population of Focus:

- Ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain healthy in the community.
- Ensure the identification of, and consistent engagement with, the Member's PCP and other specialists and behavioral health clinicians (as needed) to ensure appropriate outpatient treatment for underlying medical conditions.
- Connecting to housing-related Community Supports to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.
- Connecting the family, caretakers and circles of support to resources regarding the Member's conditions to assist them with providing support for the Member's health.
- Referring the Member and family to community services, including but not limited to county First 5s.
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.

Community Supports:
MCPs are strongly encouraged to connect Members of this Population of Focus to Community Supports where the underlying driver(s) of ED or inpatient utilization are social needs. For children with uncontrolled asthma, Asthma Remediation has a particularly compelling evidence base for reducing the need for emergency care.[21]

Provider Contracting:
MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. The appropriate ECM Provider for this Population of Focus will depend on specific needs, as well as the Member's preferences. Generally speaking, grounding ECM in primary care for this population is likely to make sense where possible, to establish a strong tie to usual and routine care grounded in trusted relationships. Please refer to Section VII. ECM Provider Network below for more information.

3. Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) Needs

Medi-Cal MCP Members with serious mental health and substance use disorder (SUD) needs, as defined below, have disproportionately high rates of chronic physical health conditions as well as complex social needs. For children and youth, a number of social conditions and risk factors (e.g., exposure to trauma or other adverse childhood experiences (ACEs)) often present as behavioral health needs. Enrolling this child and youth Population of Focus into ECM is critical to addressing risk early and averting long-term chronic illness.

CalAIM includes a suite of changes to the Medi-Cal behavioral health system to advance whole-person, accessible, high-quality care, including updates to the criteria to access specialty mental health services (SMHS). On January 1, 2022, DHCS implemented criteria for enrollees to access SMHS, medical necessity requirements, and other coverage requirements. See Behavioral Health Information Notice (BHIN)

[21] Marshall, E.T., Guo, J., Flood, E., Sandel, M.T., Sadof, M.D., Zotter, J.M. Home Visits for Children with Asthma Reduce Medicaid Costs. Preventive Chronic Disease. February 2020.

no. 26-002[22] or superseding BHIN for more information. Aligning the ECM Population of Focus eligibility criteria with this new SMHS access criteria ensures Members who are at high risk for mental health disorders, in addition to those already diagnosed, are eligible for ECM.

Implementation of ECM for this Population of Focus is designed to provide Members with a trusted Lead Care Manager who can coordinate and help integrate care and services, bridging across delivery systems. Care management through ECM may also help some MCP Members receive SMHS through the county's Mental Health Plan (MHP) who may have been undiagnosed or otherwise not yet connected to the services they need.

i. Population of Focus Eligibility Criteria:

a. Adults with Serious Mental Health and/or SUD Needs

Adults who:

(1) Meet the eligibility criteria for participation in, or obtaining services through:

(i) SMHS delivered by MHPs;

(ii) The Drug Medi-Cal Organization Delivery System (DMC-ODS) **OR** the Drug Medi- Cal (DMC) program; [23]

AND

(2) Are experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, high measure (four or more) of ACEs based on screening, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms;

AND

(3) Meet one or more of the following criteria:

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[22] BHIN 26-002 Access Criteria

[23] Further information on access criteria for the SMHS for adults and children can be found in BHIN 21-073 or superseding BHIN and for the DMC-ODS delivery system in BHIN 24-001 or superseding BHIN . The medical necessity criteria for DMC services can be found in California Code of Regulations, Title 22, § 51341.1 and BHIN 21-071 or superseding BHIN . See also Appendix B of this Policy Guide.

(i) Are at high risk for institutionalization,[24] overdose, and/or suicide;

(ii) Use crisis services, EDs, urgent care, or inpatient stays as the primary[25] source of care;

(iii) Experienced two or more ED visits or two or more hospitalizations due to serious mental health or SUD in the past 12 months;

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

b. Children and Youth with Serious Mental Health and/or SUD Needs

Children and Youth who:

(1) Meet the eligibility criteria for participation in, or obtaining services through one or more of:

(i) SMHS delivered by MHPs;

(ii) The DMC-ODS **OR** the DMC program.

No further criteria are required to be met for children and youth to qualify for this ECM Population of Focus.

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

i. Examples of Eligible MCP Members Under this Population of Focus

- A Member who is pregnant, has the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions, and who is experiencing one complex social factor influencing their health.
- A Member who is a former foster youth who has a psychiatric or SUD-related condition and is currently using EDs as the primary source of care.
- A child or youth who screens positive for four or more ACEs in their primary care practice and meets the access criteria for SMHS services but has not been linked

[24] "Institutionalization" in this context is broad and means any type of inpatient, SNF, long-term, or ED setting.
[25] From December 2022, modified from "sole" to "primary."

to care and does not have the family or social support needed to further evaluate or address their needs.

- A child or youth who is receiving services from the SMHS, DMC–ODS, and/or DMC delivery systems.

i. Operational Guidance

Identification:

- As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow Network Providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met. For children and youth, MCPs should establish robust referral pathways with all pediatric providers and should work to develop referral pathways with schools and childcare settings. DHCS expects to reflect these expectations in forthcoming updated MOU guidance to be released in 2023.
- Effective January 1, 2023, when all MCPs are expected to use ADT feed data when available across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
- MCPs and MHPs are required to enter into MOUs that define and describe in greater detail covered services and populations; screening, assessment and referral processes; care coordination requirements; oversight responsibilities of the MCP and MHP; and data and information sharing procedures, among other items. At the time of this update, DHCS is updating the MOU guidance to align with upcoming January 2024 Medi- Cal Managed Care contract procurement and will encompass federal and state developments, including strengthening requirements on referrals to ensure Members receive needed care and the California Health and Human Services Agency (CalHHS) Data Exchange Framework. Updated requirements will require that county MHPs should have specific procedures for their providers and contractors to identify and refer to MCPs clients who meet criteria for this Population of Focus.
- Members are not required to be enrolled in, or have accessed services through, SMHS, DMC-ODS, or DMC to be eligible for ECM.
- Members and their families may self-refer to ECM.
- MCPs may identify Members who meet this Population of Focus definition through analysis of Non-Specialty Mental Health Services and SUD services that are covered under MCPs, such as alcohol and drug screening; assessments; brief interventions; referral to treatment for members aged 11 and older; and

medications for addiction treatment, as described in APL 22- 005 or superseding APL. Analysis of this data allows identification of Members who might meet SMHS/DMC-ODS/DMC thresholds.

- MCPs are encouraged to partner with child care settings and LEAs to create referral pathways to help support identification of ECM eligible children and youth.

Outreach and Engagement:

ECM requires engagement with the Member in the community or at Provider locations. In instances where the Member's behavioral health provider, such as a county contracted SMHS or DMC / DMC-ODS Provider, is also their ECM Provider, ECM services could be provided wherever they receive behavioral health services.

Comprehensive Assessment and Care Management Plan:

ECM is a whole person care management benefit which includes coordinating the medical and social needs beyond the Member's mental health or SUD conditions. Thus, when serving as ECM Provider, the county behavioral health agency and/or its subcontracted SMHS/DMC/DMC-ODS Providers must also document and manage those needs beyond the clients' mental health or SUD needs.

When a county behavioral health agency or its contracted provider is also serving as an ECM Provider, MCPs must avoid imposing assessment requirements that are duplicative of the SMHS/DMC/DMC-ODS screening domain requirements. In practice, this might require MCPs to develop modified assessment policy/templates. The county behavioral health agency or its contracted provider may start by utilizing the SMS/DMC/DMC-ODS screening domain requirements (as described in BHIN 23-068 or any superseding guidance) and add any missing component (i.e., physical health required for "whole person" ECM assessment).

BHIN 23-068 or superseding BHIN seeks to streamline and standardize clinical documentation requirements across Medi-Cal, SMHS, DMC, and DMC-ODS services by allowing creation of progress notes to document treatment and care plans, including for the required SMHS Targeted Case Management (TCM) care planning documentation elements. MCPs must not impose care planning documentation requirements that duplicate existing SMHS/DMC/DMC- ODS Provider processes, but instead work with the county behavioral health agency and/or their subcontracted SMHS/DMC/DMC-ODS Providers to meet both ECM and SMHS/DMC/DMC-ODS care planning requirements in a way that leverages existing documentation processes. Specifically, the county behavioral health agency and/or their subcontracted

SMHS/DMC/DMC-ODS Providers may use the progress note approach as the method of recording the ECM care plan as long as the following principles are taken into account:

- ECM is a whole person care management benefit, which includes coordinating the medical and social needs beyond the Member's mental health or SUD conditions. Thus, the county behavioral health agency and/or its subcontracted SMHS/DMC/DMC-ODS Providers must also document and manage those needs beyond the clients' mental health or SUD needs.
- If the county behavioral health agency and/or their subcontracted SMHS/DMC/DMC-ODS Providers use the progress note approach, they must be able to communicate the content of the full care plan to other providers and to the Member themselves, in order to meet ECM requirements. MCPs must reflect these provisions on recording an ECM care plan in their contracts with counties.

Examples of Applicable ECM Services for this Population of Focus:

- Facilitating regular culturally and linguistically appropriate contact with Members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community.
- Facilitating referral for Members and their families to home and community supports for early childhood, infant and early childhood mental health (IECMH), such as county First 5s.
- Connecting to housing-related Community Supports to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.
- Supporting the Member's behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.
- Connecting the family, caretakers and circles of support to resources regarding the Member's conditions to assist them with providing support for the Member's health and behavioral health.
- Coordinating and collaborating with various health, behavioral health, developmental disability and social services Providers, including sharing data (as appropriate).

- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Identifying and coordinating among other care managers across delivery systems who have been assigned to assist the individual with any aspect of their health and related social needs.
- Understanding and identifying root causes of a Member's behavioral health need, particularly with children and youth who may not have a diagnosed SMHS or DMC-ODS/DMC condition but require additional supports and care due to family dynamics, social situations, historical trauma, and other concerns, all requiring a multi-agency approach and solution to appropriately address for the child or youth.

Community Supports:

MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus. Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations.[26] While nearly all Community Supports may be relevant for individuals with SMI or serious emotional disturbance (SED) depending on their needs, examples of Community Supports that Members of this Population of Focus may benefit from include:

- Sobering Centers (including ensuring communication and coordination between ECM Providers and Sobering Centers for assigned members receiving Community Supports sobering center services).
- Housing Transition Navigation Services.
- Housing Deposits.
- Housing Tenancy and Sustaining Services.
- Short-Term Post-Hospitalization Housing.

[26] For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the Community Supports Policy Guide, Volume I (non-housing) and Volume II (housing).

- Medically Supportive Food/Meals/Medically Tailored Meals.

Provider Contracting (Updated January 2026):

MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. Members in this Population of Focus are also likely receiving SMHS services through county MHPs and/or SUD services through DMC- ODS or DMC programs. Therefore, it is important for MCPs to coordinate with county behavioral health agencies and providers to ensure continuity of care and nonduplication of care management services with ECM. As such, the DHCS MCP contract **requires that MCPs must prioritize contracting with county behavioral health agencies or their subcontracted providers to serve as ECM Providers,** provided they agree and are able to coordinate all services needed by the Member, not just behavioral health services; and unless the Member (or their parent, guardian, or caretaker) desires a different ECM Provider. Please refer to Section VII. ECM Provider Network below for more information.

When MCPs are not able to contract with the county behavioral health agency or its subcontracted provider as the ECM Provider, the ECM Provider for a Member within this population should have experience and expertise working with individuals with serious mental health needs and SUD, as well as the ability to adequately coordinate services across multiple delivery systems. MCPs are also encouraged to contract with behavioral health providers and their care teams who meet the needs of individuals from pregnancy through 12 months postpartum.

For the children and youth in this Population of Focus, given the broader ECM eligibility criteria, it is possible that the county MHPs or their subcontracted Providers may not have sufficient capacity to serve all ECM eligible children and youth. MCPs should work closely with the county behavioral health agency to determine which sub-populations would best be served by a county behavioral health ECM Provider (e.g., those with ongoing mental health or SUD needs) versus an alternative community- based provider that may be better poised to meet the underlying social and other needs of the Member (e.g., a dyadic services provider integrated with the Member's primary care clinic).

4. Individuals Transitioning from Incarceration

Many Members transitioning from incarceration have disproportionately high physical and behavioral health care needs that require ongoing treatment and medication maintenance when they are released into the community. Individuals re-entering the community often experience a lack of continuous physical and behavioral health care which results in a deterioration of their physical and behavioral health conditions,

increased use of EDs and inpatient settings, and, in some instances, a return to incarceration.

On January 26, 2023, California became the first state in the nation to receive federal approval to offer a targeted set of Medicaid services to Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. Through a federal Medicaid 1115 demonstration waiver approved by the Centers for Medicare and Medicaid Services (CMS), DHCS will work with implementing partners to establish a coordinated community reentry process that will assist people leaving incarceration in connecting to the services they need prior to release and upon reentering their communities.

Care management is a critical component of the CalAIM Justice Involved Reentry Initiative, which is intended to (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care delivered in the community. The care management model begins with pre-release care management services available during the 90 days prior to an individual's release, which are paid on an FFS basis by Medi-Cal. The pre-release care manager is required to closely coordinate with the individual's post-release ECM provider– if the pre-release and post-release care managers are not the same person – to ensure continuity of care between the pre- and post-release periods. The ECM Individuals Transitioning from Incarceration Population of Focus went live **January 1, 2024.**

To ensure alignment across pre-release care management and post-release ECM, the Eligibility criteria for the Individuals Transitioning from Incarceration Population of Focus listed below and detailed in Appendix C aligns with the eligibility criteria for individuals who are incarcerated to receive targeted pre-release Medi-Cal services. Therefore, all Members who have received pre-release services will be eligible for this ECM POF. However, members do not need to have received pre-release services to be eligible for this Population of Focus if they meet the eligibility criteria (e.g., if they were released from a correctional facility prior to go-live of pre-release services).

i. Population of Focus Eligibility Criteria:

a. Adults Transitioning from Incarceration

Adults who:

(1) Are transitioning from a correctional facility (e.g., prison, jail, or youth correctional facility) or transitioned from correctional facility within the past 12 months;

AND

(2) Have at least one of the following conditions (See Appendix C for definitions):

(i) Mental illness;

(ii) Substance Use Disorder (SUD);

(iii) Chronic Condition/Significant Non-Chronic Clinical Condition;

(iv) Intellectual or Developmental Disability (I/DD);

(v) Traumatic Brain Injury (TBI);

(vi) HIV/AIDS;

(vii) Pregnant or Postpartum

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

b. Children and Youth Transitioning from a Youth Correctional Facility

Children and youth under 21 or former foster youth between 18 and 26 who are transitioning from a youth correctional facility or adult jail/prison or transitioned from being in a youth correctional facility or adult jail/prison within the past 12 months. No further criteria are required to be met for Children and Youth to qualify for this ECM Population of Focus.

ii. Examples of Eligible MCP Members Under this Population of Focus (Updated January 2026):

- A Member who has a SUD diagnosis, was incarcerated 3 months ago in a county jail for 2 days, did not receive pre-release services while incarcerated, and was referred to the MCP by a federally qualified health center (FQHC).
- A Member who has HIV, was incarcerated in a California state prison for two years, was found eligible for and received targeted pre-release services which included pre-release care management and began receiving post-release ECM services beginning the day of their release.

- A Member who is pregnant or within 12 months postpartum and is transitioning from a jail.
- A youth Member was incarcerated in a youth correctional facility for 30 days, was found eligible for and received targeted pre-release services, and began receiving post-release ECM services beginning the day of their release.

iii. Operational Guidance:

For detailed operational guidance on the implementation of ECM for this Population of Focus, please reference the CalAIM Policy and Operational Guide for Justice-Involved initiative CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance

5. Adults Living in the Community and At Risk for LTC Institutionalization

Intensive care coordination through ECM can help adults continue to reside in the community who would otherwise have entered into an institutional setting for care.

i. Population of Focus Eligibility Criteria:

Adults Living in the Community and At Risk for LTC Institutionalization

Adults who:

(1) Are living in the community who meet the SNF Level of Care (LOC) criteria;[27] **OR** who require lower-acuity skilled nursing, such as time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury; [28]

AND

(2) Are actively experiencing at least one complex social or environmental factor influencing their health (including, but not limited to, needing assistance with activities of daily living (ADLs), communication difficulties, access to food, access to stable housing, living alone, the need for conservatorship or guided decision- making, poor or

[27] As established in the California Code of Regulations § 51335.

[28] Criteria adapted from the 2020 Medi-Cal Long-Term Care At Home proposal.

inadequate caregiving which may appear as a lack of safety monitoring);[29]

AND

(3) Are able to reside continuously in the community with wraparound supports (i.e., some individuals may not be eligible because they have high-acuity needs or conditions that are not suitable for home-based care due to safety or other concerns).

Notes on the Definition:

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

- **Living in the Community.** Members who meet this Population of Focus may live in independent housing, Residential Care Facilities, Residential Care Facilities for the Elderly (RCFEs), or any other dwelling that meets the requirements established in the Home and Community Based Services (HCBS) Settings Final Rule. [30] This includes those receiving the ALFT Community Support.
- **Exclusions**. Adults living in the community who are at risk of institutionalization into Intermediate Care Facilities (ICF) [31]and subacute care facilities[32] are excluded from this Population of Focus.

ii. Examples of Eligible MCP Members Under this Population of Focus:

- A 65-year-old Member with cancer who underwent surgery for Gastrostomy tube placement; the Member needs assistance with Gastrostomy tube feedings and maintenance of the site, personal care services and medication administration.

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[29] Criteria adapted from the Community-Based Health Home eligibility criteria.

[30] CMS Final Rule 79 FR 2947, Medicaid Program; State Plan Home and Community- Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and HCBS Waivers; 42 CFR § 441.301(c)(4) and (5).

[31] Definition and more information about Intermediate Care Facilities (ICFs) located is located on the Department of Developmental Services website.

[32] Definition and more information about subacute care facilities is located on the DHCS website.

- A 75-year old Member who was recently discharged from the hospital after suffering a stroke; the Member lives alone and will need In Home Supportive Service (IHSS) services, nursing visits for medication management, meal preparation, potentially additional personal care services beyond what IHSS may authorize, and coordination of transportation to a rehabilitation clinic for bi- weekly physical and occupational therapy services.

iii: Operational Guidance:

Identification:

- Referrals are expected to be the predominant pathway MCPs identify Members who may be eligible for ECM through this Population of Focus. MCPs are encouraged to leverage existing and develop new partnerships with Providers who have experience serving Members who meet this Population of Focus eligibility criteria and are thus well positioned to make referrals. This includes but is not limited to Community-Based Adult Services (CBAS) Centers, Area Agencies on Aging, Home Health Agencies, Centers for Independent Living, IHSS Providers, and other HCBS Waiver Providers.
- Members and their families may self-refer to ECM.
- Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
- MCPs are encouraged to establish relationships with Adult Protective Services (APS) agencies. [33] Each county in California has an APS agency specifically dedicated to helping elder and dependent adults, and regularly meet with individuals in their homes. These agencies may serve as a useful referral source.
- MCPs may also utilize existing Member data, establish regular data sharing arrangements with contracted Providers, or leverage 1915(c) HCBS waiver program wait lists to identify Members who may meet this Population of Focus definition. MCPs may use previous SNF LOC determinations to confirm Member eligibility. The 1915(c) waiver programs[34] require Members to meet the SNF LOC criteria to be eligible for participation. As such, SNF LOC determination may have already been made for some Members who meet this Population of Focus.

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[33] Please review the APS Offices by County list for more information.

[34] Assisted Living Waiver (ALW), Home and Community Based Alternatives (HCBA) Waiver, and Multipurpose Senior Services Program (MSSP) Waiver.

- Member choice and preferences must be considered during the identification and eligibility determination process before enrolling Members into ECM, when assigning them to an ECM Provider, and when designing the Member's care plan.

Comprehensive Assessment & Care Management Plan:

Once a Member is enrolled in ECM, a comprehensive assessment should be conducted, and care plan developed, as described in Section V. Core Service Components of ECM. As part of the assessment, MCPs must include DHCS' standardized LTSS referral questions [35] to identify and refer Members who may have LTSS needs, unless the Member has already answered these questions. Assessments should be conducted face-to-face and in the community whenever possible.

Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, using a person-centered process. [36] Thus, for this Population of Focus, the ECM Lead Care Manager must meet these requirements. The care plan should consider and reflect what is important to the Member regarding their preferences for the delivery of LTSS (for example, specific treatment goals, services or functional needs the Member prefers to prioritize). As for all ECM Populations of Focus, the care plan should incorporate the Member's needs across all delivery systems inclusive of LTSS, and must contain the services and supports that will ensure the Member is setup to live continuously in the community.

Community Supports:

MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus. [37] Doing so can enhance care, prevent costly and unnecessary hospitalizations, and help Members live continuously in the community. Each Member will have different needs and functional limitations. Community Supports that may be particularly beneficial include:

- Environmental Accessibility Adaptations (Home Modifications).
- Respite Services.

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[35] As established in APL 17-013 or superseding APL.

[36] As established in 42 CFR § 438.208 and 42 CFR § 441.301.

[37] For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the Community Supports Policy Guide, Volume I (non-housing) and Volume II (housing).

- Personal Care and Homemaker Services.
- Medically Tailored Meals/Medically Supportive Food.

ECM Provider Contracting:

MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. The ECM Providers who may be best to equipped to serve this Population of Focus may include, but are not limited to, CBAS Centers, Area Agencies on Aging, Home Health Agencies, Alzheimer's Association, and Centers for Independent Living. Please refer to Section VII. ECM Provider Network below for more information.

6. Adult Nursing Facility Residents Transitioning to the Community

Intensive care coordination through ECM can help nursing facility residents transition safely into the community.

i. Population of Focus Eligibility Criteria:

Adult Nursing Facility Residents Transitioning to the Community

Adult nursing facility residents who:

(1) Are interested in moving out of the institution; **AND**

(2) Are likely candidates to do so successfully; **AND**

(3) Are able to reside continuously in the community.

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

Notes on the Definition:

- **Able to Reside Continuously in the Community.** Members transitioning to the community may need to return to the hospital or SNF intermittently for short admissions (potentially due to changes in medical conditions or other acute episodes). They should not be precluded from being considered able to reside continuously in the community. This includes members receiving the ALFT and the Community or Home Transition Services Community Support.

- **Exclusions.** Individuals residing in ICFs [38] and subacute care facilities[39] are excluded from this Population of Focus.

ii. Examples of Eligible MCP Members Under this Population of Focus:

- A 70-year-old Member with multiple chronic conditions and social needs who has been residing in a SNF for the past 6 months after recovering from a stroke; the Member currently does not have a residence to return to but has indicated on the Minimum Data Set (MDS) assessment that they would like to transition back to the community. As far as the facility knows, the Member does not have family supports.
- A 58-year-old Member with Lou Gehrig's disease (ALS) who has been residing in a SNF for the past year; prior to their admission into the SNF, they had been living with family members; recently, they expressed an interest to their SNF care coordinator in returning home.

iii. Operational Guidance:

Identification:

- MCPs can rely on referrals, analysis of their own data, or direct data feeds from and relationships with SNFs or other Providers to identify Members who may be eligible for this Population of Focus.
- Members and their families may self-refer to ECM.
- Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, for their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
- One of the pathways MCPs can leverage is the MDS, which is part of the federally mandated process for clinical assessment of all residents in certified nursing facilities. MDS assessments are completed for all residents, regardless of source of payment, and are required on admission to the nursing facility, periodically, and upon discharge.[40] Section Q of the MDS uses a person-centered approach to ensure that all individuals residing in the SNF have the opportunity to indicate their interest in receiving long term care in the least

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[38] Definition and more information about Intermediate Care Facilities (ICF) is located on the Department of Developmental Services website.

[39] Definition and more information about subacute care facilities is located on the DHCS website.

[40] See MDS 3.0 Public Reports.

restrictive setting possible. [41] MCPs who have access to MDS assessment data are encouraged to analyze responses to Section Q on a regular basis to identify Members who may be eligible for this Population of Focus.

- MCPs are encouraged to leverage existing and develop new partnerships with SNFs and Providers who have experience serving Members who meet this Population of Focus, and are thus well positioned to make referrals. This includes but is not limited to Area Agencies on Aging, and California Community Transitions (CCT) Money Follows the Person (MFTP) Lead Organizations. MCPs should also institute data sharing requirements with their contracted SNF Providers.

Comprehensive Assessment and Care Management Plan:

The assessment and care management plan processes for Members who meet this Population of Focus are expected to be time intensive. MCPs must assess Members against criteria to determine who could be successful to reside continuously in the community, which may include but is not limited to functional status, the availability of appropriate services and resources in the community, existing support systems, and safety. DHCS encourages MCPs to use the CCT assessment tool for this Population of Focus. This tool is already being used across the state to successfully transition Members from SNFs into home and community- based settings, and could serve as a helpful resource.

The development of the care plan for a Member to transition from SNF to the community is an effort that will require considerable planning. The ECM Care Manager is responsible for identifying all resources to address all needs of the Member, including coordinating with local housing agencies and identifying the least restrictive community housing option, ongoing medical care that may be needed, and other community-based services to ensure a Member will be able to transition and reside continuously in the community. The development of the care plan should be led by the ECM Lead Care Manager and involve the Member, their family and friends (as requested), legal representative (as applicable), and the interdisciplinary care team, the SNF facility discharge planner, and any other relevant clinical, behavioral health, and social work staff.

Per federal requirements, if the Member has LTSS needs, the care plan must be developed by an individual who is trained in person-centered planning, using a person-

[41] See CMS 3.0 Manual

centered process. [42] Thus, for this Population of Focus, the ECM Lead Care Manager must meet these requirements. The care plan should consider and reflect what is important to the Member regarding their preferences for the delivery of LTSS (for example, specific treatment goals, services or functional needs the Member prefers to prioritize). As for all ECM Populations of Focus, the care plan should incorporate the Member's needs across all delivery systems inclusive of LTSS, and must contain the services and supports that will ensure the Member is setup to live continuously in the community.

Community Supports:

MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.[43] Doing so can enhance care, prevent costly and unnecessary hospitalizations, and help Members live continuously in the community. Each Member will have different needs and functional limitations. Community Supports that may be particularly beneficial include:

- Community Transition Services/Nursing Facility Transition to a Home.
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as RCFE and Adult Residential Facilities (ARF).
- Medically Tailored Meals/Medically-Supportive Food
- Environmental Accessibility Adaptations (Home Modifications)
- Personal Care and Homemaker Services
- Respite Services

A Member can receive ECM and can also simultaneously receive the care management included in these Community Supports services. For MCPs offering these Community Supports services, they are encouraged to assign the same Community Supports Provider as the ECM Provider, so long as the Community Supports Provider is contracted as an ECM Provider, and is therefore able to coordinate all services needed. If a different Community Supports Provider and an ECM Provider are both serving a Member at the same time, the ECM Provider remains primarily responsible for the

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[42] As established in 42 CFR § 438.208 and 42 CFR § 441.301.

[43] For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the Community Supports Policy Guide, Volume I (non-housing) and Volume II (housing).

overall coordination across the physical and behavioral health delivery systems and social supports.

Provider Contracting:

MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. MCPs are strongly encouraged to contract with CCT Lead Organizations to serve Members who meet this Population of Focus, as these Providers have existing relationships with community-based organizations, can coordinate community wrap around supports effectively, and have extensive knowledge of existing local community resources (e.g., housing wait lists). Please refer to Section VII. ECM Provider Network below for more information. See Section VI. Program Overlaps and Exclusions for interactions with programs for Medi-Cal MCP Members dually eligible for Medicare.

7. Children and Youth Enrolled in CCS or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition

CCS and CCS WCM serve some of Medi-Cal's most vulnerable children. In addition to their physical health condition qualifying them for CCS/CCS WCM – such as cancer, cerebral palsy, and cystic fibrosis (see full eligibility criteria on the DHCS website) – these children often experience a high co-occurrence of social and behavioral health challenges beyond their CCS/CCS WCM qualifying condition. As a result, many children in CCS/CCS WCM work with multiple care/case managers to navigate many delivery systems, creating a need for the child's guardian or other advocate to navigate a variety of fragmented care delivery systems and discordant care plans. For this population, a dedicated ECM Lead Care Manager can help take the navigational burden off children and their families, while helping Providers from the varied delivery systems harmonize with the family-centered plan of care. ECM Care Managers act as the main point for contact for ECM and are responsible for whole- child care coordination between and among all participants in the child's care plan, thereby ensuring each child's needs are met.

i. Population of Focus Eligibility Criteria:

Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition

Children and youth who:

(1) Are enrolled in CCS **OR** CCS WCM;

AND

(2) Are experiencing at least one complex social factor influencing their health. Examples include (but are not limited to) lack of access to food; lack of access to stable housing; difficulty accessing transportation; high measure (four or more) of ACEs screening; history of recent contacts with law enforcement; or crisis intervention services related to mental health and/or substance use symptoms.

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

ii. Examples of Eligible MCP Members Under this Population of Focus (Updated January 2026):

- Child enrolled in CCS due to their cerebral palsy and child's family requests assistance to address food insecurity within the child's household.
- Child enrolled in CCS WCM due to traumatic injuries from a car accident and developed post-traumatic stress disorder due to the accident, and has a recent law enforcement interaction.
- Pregnant youth enrolled in CCS due to their sickle cell disease and challenges accessing transportation for prenatal care appointments.
- Toddler enrolled in CCS while in the hospital to treat recent lead poisoning and will continue receiving chelation medication on an outpatient basis. The child is clinically ready for hospital discharge, but cannot safely transfer home because the family cannot afford the necessary repairs to abate the environmental lead housing hazards identified by the local health department inspector.

iii. Operational Guidance:

Identification:

- As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow Network Providers to refer Members to the MCP for
- ECM if they suspect eligibility criteria are met. Specialty Care Center (SCC) Coordinators, other Members of the child's SCC core team (including pediatricians, PCPs, specialty care providers, and others), and local CCS county offices, especially, may all submit referrals for Members they suspect are eligible for ECM.

- Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
- Members and their families may self-refer to ECM.
- MCPs may also identify eligible Members for ECM through analysis of CCS/CCS WCM enrollment and additional data available to MCPs, including zcodes identifying SDOH and high measures on ACEs screening.
- Children in CCS or CCS WCM are eligible to receive ECM if they meet the criteria of any other ECM Population of Focus, even if they do not have a complex social factor that causes them to meet the criteria in Clause (2) of this Population of Focus. For example, many children in CCS have a co- occurring behavioral health need; these children would be eligible for ECM.

Outreach and Engagement:
ECM requires engagement with the Member in the community or at Provider locations. In instances where the Member's CCS/CCS WCM Provider is also their ECM Provider, ECM services could be provided at their SCC or wherever they receive CCS/CCS WCM services.

Comprehensive Assessment and Care Management Plan:
The ECM Provider is expected to leverage CCS' comprehensive assessment (includes psychosocial, cognitive, developmental assessing, and planning) and the care plan developed by CCS in developing the Member's ECM care management plan. Additional assessments may be needed to ensure the Member's ECM care management plan incorporates the Member's needs and strategies to address those needs across the areas of physical health care, mental health care, SUD care, community-based LTSS, oral health care, palliative care, social supports, SDOH care, and others.

The ECM Provider is expected to leverage CCS WCM's Individual Care Plan (ICP) (includes physical health care, mental health care, SUD care, home health needs, and Regional Center needs) when developing the Member's ECM care management plan. CCS WCM Members also undergo a risk stratification and annual assessment (includes general health status, recent health care utilization, health history, medical history, demographics, and social history) on Members' risk-levels and CCS eligibility determination, all of which should be considered when developing the Member's ECM care management plan.

Examples of Applicable ECM Services for this Population of Focus: For this Population of Focus, ECM should include addressing other needs that are not already

being met by CCS/CCS WCM. Examples of applicable ECM services for this population include (but are not limited to):

- Facilitating access to the Environmental Accessibility Adaptions (Home Modifications) Community Support to have ramps and a stair lift installed in the Member's home (see more below).
- Facilitating referral for Members and their families to home and community supports for early childhood, such as county First 5s.
- Coordinating the transition from hospital to inpatient rehabilitation and to home after a traumatic injury.
- Coordinating care across all applicable delivery systems (Medi-Cal Managed Care or Medi-Cal FFS; SMHS; DMC or DMC-ODS; Dental Managed Care or FFS; and Medi-Cal Rx) and care coordinators.

Community Supports:

MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.[44] Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:

- Personal Care and Homemaker Services.
- Environmental Accessibility Adaptions (Home Modifications).
- Respite Services.
- Medically Tailored Meals/Medically-Supportive Food.
- Asthma Remediation.

Provider Contracting:

- MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. Please refer to Section VII. ECM Provider Network below for more information.

[44] For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the Community Supports Policy Guide, Volume I (non-housing) and Volume II (housing).

- If a child or youth is enrolled in both ECM and CCS/CCS WCM and their CCS/CCS WCM Provider elects to become a contracted ECM Provider, then the MCP should assign the CCS/CCS WCM Provider as that Member's ECM Provider, unless the Member (and/or their parent, guardian, caretaker) prefers a different ECM Provider.
- MCPs that offer CCS WCM are expected to adhere to all ECM requirements including contracting with community-based Providers, even if CCS WCM is delivered in house at the MCP. Where it is appropriate, CCS WCM elements can be delegated to ECM Providers to ensure children and youth receive comprehensive, non-duplicated care across ECM and CCS WCM.

8. Children and Youth Involved in Child Welfare [45]

Children and youth in California who are currently or were previously involved in Child Welfare Services provided through the California Department of Social Services (CDSS) often experience an extraordinary amount of transition and fragmentation of health care, social support services, and adult advocates in their childhoods. Research supports that those negative impacts which occur during these experiences may affect their physical and mental health beyond childhood. Many of the children in child welfare have co-occurring mental health and substance use treatment needs that are often unmet due to the challenge of navigating multiple and siloed service delivery systems. ECM Care Managers act as the main point for contact for ECM and are responsible for whole-child care coordination between and among all participants in the child's care plan, thereby ensuring each child's needs are met.

i. Population of Focus Eligibility Criteria:

Children and Youth Involved in Child Welfare

Children and youth who meet one or more of the following conditions:

(1) Are under age 21 and are currently receiving foster care in California;

(2) Are under age 21 and previously received foster care in California or another state within the last 12 months;

(3) Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state;

[45] ECM is a Medi-Cal managed care benefit and only available to Members enrolled in Managed Care.

(4) Are under age 21 and are eligible for and/or in California's Adoption Assistance Program;

(5) Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization of ECM.

Notes on the Definition:

- Foster care is defined in California by Welfare and Institutions Code (WIC) 11400(f) as the "24-hour out-of-home care provided to children whose own families are unable or unwilling to care for them, and who are in need of temporary or long-term substitute parenting."
- California's Adoption Assistance Program is defined by WIC 16120 and available to children under age 18 *or* under age 21 if the child has a mental or physical disability that warrants the continuation of assistance, per WIC 16120(d) Adoption Assistance Program provides financial and medical coverage with the goal of facilitating the adoption of children who otherwise may have remained in long-term foster care. Adoption Assistance Program is provided for up to five years.
- California's Family Maintenance program is defined by WIC 16506 as services that "shall be provided or arranged for by county welfare department staff in order to maintain the child in his or her own home." Family Maintenance provides strength-based, family-focused services to support a child or youth remaining in a safe, secure, stable home. Services are only eligible up to age 18.

ii. Examples of Eligible MCP Members Under this Population of Focus (Updated January 2026):

- A Member under age 21 who is currently receiving foster care services.
- A Member under age 21 who has received foster care services any time in the last 12 months.
- A Member up to age 18 (or under age 21 for children with a "mental or physical disability") who is eligible for and/or are in California's Adoption Assistance Program.
- A Member up to age 18 who is receiving (or has received in the last 12 months) Family Maintenance services.

- A Member under age 21 who is currently receiving foster care services and is pregnant or within 12 months postpartum.

iii. Operational Guidance:

Identification:

- Members and their families may self-refer to ECM.
- MCPs have access to aid codes and eligibility groups that can help identify children and youth involved in child welfare, specifically for children receiving foster care, children with an approved relative caregiver, children who are in the former foster care youth eligibility group, children who are in the Adoption Assistance Program (see Appendix D for more information on the aid codes and eligibility groups). MCPs will need to access other information and data to help identify children eligible for ECM through this Population of Focus who are eligible for or enrolled in Family Maintenance or they were eligible for Adoption Assistance Program but not enrolled.
- California Wraparound Care Coordinators, Health Care Program for Children in Foster Care (HCPCFC) Public Health Nurses, other support staff of these programs, county child welfare program staff, and any local program supporting children involved in child welfare all may submit referrals for members they suspect are eligible.

Outreach and Engagement:

ECM requires engagement with the Member in the community or at ECM Provider locations. In instances where the Member's California Wraparound Care Coordinator or HCPCFC Public Health Nurses is also their ECM Provider, ECM services could be provided where the Member receives California Wraparound or HCPCFC services.

For Members who also have a Child Family Team (CFT) through California Wraparound, the ECM Provider is expected to consult with them and keep them informed as appropriate.

Comprehensive Assessment and Care Management Plan:

For children enrolled in California Wraparound or HCPCFC, the ECM Provider is expected to leverage the comprehensive assessments conducted and the care plans developed by California Wraparound (called a "Wraparound Plan") and HCPCFC (called a "care plan" and coupled with a "Health Education Passport" to document medical and education information) in developing the Member's ECM care management plan. The California Wraparound Plan is developed in partnership with the CFT and includes clinical and nonclinical information. The HCPCFC care plan includes an assessment of medical,

dental, developmental, behavioral, personal and child welfare history, and other applicable SDOH care.

Additional assessments may be needed to ensure the Member's ECM care management plan incorporates the Member's needs and strategies to address those needs across the areas of physical health care, mental health care, SUD care, community-based LTSS, oral health care, palliative care, social supports, SDOH care, and others.

Examples of Applicable ECM Services for this Population of Focus: For this Population of Focus, ECM should include addressing other needs that are not already being met by California Wraparound or HCPCFC. Examples of applicable ECM services for this population include (but are not limited to):

- Facilitating enrollment in SNAP.
- Facilitating referral for Members and their families to home and community supports for early childhood, such as county First 5s.
- Supporting enrollment in educational opportunities and grants, such as Cal Grant B for Foster Youth and Chafee Foster Youth Grant Program.
- Assisting the Member with scheduling appointments with their PCP and coordinating referrals to specialists.
- Ensuring the Member's foster parents have the resources and knowledge to monitor the Member's medication-assisted treatment to address a SUD.

Community Supports:

- MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.[46] Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:
- Day Habilitation Programs.
- Medically Tailored Meals/Medically-Supportive Food.

[46] For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the Community Supports Policy Guide, Volume I (non-housing) and Volume II (housing).

- Environmental Accessibility Adaptions (Home Modifications).
- Asthma Remediation
- Transitional Rent Transitional Housing Programs
- Respite Services
- Personal Care and Homemaker Services

Provider Contracting:

- MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. Please refer to Section VII. ECM Provider Network below for more information.
- If a child or youth is already enrolled in California Wraparound or HCPCFC and requires ECM services, MCPs should verify whether any of the Members' other care management providers are contracted to provide ECM. If so, the MCP should assign one of these providers as that Member's ECM Provider whenever possible, unless the Member (and/or their parent, guardian, caretaker) prefers a different ECM Provider. This approach can decrease both fragmentation and coordination burden across multiple teams.

9. Birth Equity Population of Focus [47]

Pregnant and postpartum individuals often require care that is accessed across many delivery systems to support themselves and their newborn. Pregnant and postpartum individuals can receive ECM if they qualify under any of the ECM Populations of Focus, including those that already are in effect as of January 1, 2022, and those that will go into effect in future months. Given the significant racial and ethnic disparities in maternal outcomes in California, effectively addressing the needs of this population is a critical part of DHCS' health equity vision.

Starting January 1, 2024, the Birth Equity Population of Focus will go live to address known disparities in health and birth outcomes in racial and ethnic groups with high

[47] ECM has been available to pregnant and postpartum adults from the launch of ECM if they meet the eligibility criteria for any existing Population of Focus. In July 2023, youth who are pregnant or postpartum will also be eligible for ECM if they meet the eligibility criteria for any existing Population of Focus. See Section VI. Program Overlaps and Exclusions for more details about individuals who are pregnant and postpartum and eligible for ECM and receiving services from existing care management programs.

maternal morbidity and mortality rates. DHCS added this Population of Focus in 2022 in recognition that living within communities subject to historically poor birth outcome disparities related to social inequity is itself a risk factor that can be addressed through comprehensive, whole-person care management. DHCS is announcing this change simultaneous with the launch of Children and Youth Population of Focus in recognition of the tie between investment in perinatal care and outcomes for children and youth, especially those who are zero to three years of age.

i. Population of Focus Eligibility Criteria:

Birth Equity Population of Focus (Adults and Youth)

Adults and youth who:

(1) Are pregnant **OR** are postpartum (through 12 months period);

AND

(2) Are subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

No further criteria are required to be met to qualify for this ECM Population of Focus. MCPs may not impose additional eligibility requirements for authorization

Notes on the Definition:

- The Birth Equity Population of Focus went live on January 1, 2024.
- Clause (1) with "pregnant or are postpartum," with "postpartum" period defined as the 12 month period following the last day of the pregnancy (irrespective of whether live or still birth delivery, or spontaneous or therapeutic abortion).
- Clause (2) is identified based on the California Department of Public Health's (CDPH) most recent State public health data available on the Women/Maternal Dashboard Home Page (including the Pregnancy Related Mortality, Selected Maternal Complications, and Severe Maternal Morbidity Dashboards).

ii. Examples of Eligible MCP Members Under this Population of Focus:

- Black, American Indian or Alaska Native, or Pacific Islander Member who is pregnant or postpartum (up to 12 months) and does *not* qualify for ECM through another Population of Focus *(go live on January 1, 2024)*.

iii. Operational Guidance

Identification (Updated January 2026):

- MCPs must work to identify eligible Members for this Population of Focus as soon as they become aware of a Member's pregnancy (e.g., encounter data, Provider records or reports). MCPs must have strategies in place to support timely identification of a Member's pregnancy and not rely solely on claims and encounter data, which have significant lag time.
- DHCS and MCPs collect race and ethnicity data at multiple interventions (e.g., eligibility, enrollment, Provider recorded). MCPs will be expected to leverage any data source available to them in order to identify pregnant and postpartum (up to 12 months) individuals who may experience health disparities with maternal morbidity and mortality (aligned with Clause (2)).
- MCPs should partner with local programs serving pregnant and postpartum individuals to help with identification, including Comprehensive Perinatal Services Program (CPSP), Black Infant Health (BIH) Program, California Perinatal Equity Initiative (PEI), county First 5s, Indian Health Program, American Indian Maternal Support Services (AIMSS), CDPH's California Home Visiting Program (CHVP), CDSS' CalWORKs Home Visiting Program (HVP), county behavioral health programs, local Women, Infants, and Children (WIC) agencies, local food banks, local diaper banks, and CBOs supporting individuals experiencing intimate partner violence.
- As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow Network Providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met. MCPs should specifically focus on establishing robust referral pathways with all maternity care providers, including midwives, doulas, and hospitals to identify and refer eligible Members.
- Effective January 1, 2023, when all MCPs are expected to use ADT feed data, when available, across their PHM Programs, MCPs should use ADT feed data to identify potentially eligible members in a timelier fashion.
- Members and their families may self-refer to ECM. While Members may self-refer, MCPs are responsible for reviewing eligibility to ensure authorizations are only for individuals that meet eligibility criteria.

Outreach and Engagement:

- ECM requires engagement with the Member in the community or at Provider locations. In instances where the Member is also enrolled in a local pregnant or postpartum program (i.e., CPSP, BIH Program, PEI, First 5, AIMSS, CHVP,

HVP) and that program is also their ECM Provider, ECM services could be provided where the Member receives those services.

- In instances where the Member is enrolled in a local pregnant or postpartum program (i.e., CPSP, BIH Program, PEI, First 5, AIMSS, CHV, HVP) and that program is not their ECM Provider, the ECM Provider is expected to consult with the local pregnant or postpartum program and keep them informed as appropriate.

Comprehensive Assessment and Care Management Plan:

- For Members enrolled in CPSP, the ECM Provider is expected to leverage the comprehensive assessments conducted by CPSP, including the CPSP individualized care plan and postpartum assessment, in developing the Member's ECM care management plan. [48] The CPSP individualized care plan is reassessed at each trimester with a strengths-based assessment.
- Additional assessments may be needed to ensure the Member's ECM care management plan incorporates the Member's needs and strategies to address those needs across the areas of physical health care, mental health care, SUD care, community-based LTSS, oral health care, palliative care, social supports, SDOH care, and others.
- A Member who qualifies for ECM through this Population of Focus would not be disenrolled from ECM simply because their pregnancy and/or postpartum period concludes. Rather, just as any other Member enrolled in ECM, a Member who is enrolled in ECM through this Population of Focus would only disenroll if they meet graduation criteria.

Examples of Applicable ECM Services for this Population of Focus:

For this Population of Focus, ECM should include addressing the needs of the pregnant or postpartum individual to ensure the best health and lifelong outcomes for them, as well as their newborn or infant. Examples of applicable ECM services for this Population of Focus include (but are not limited to):

- Facilitating access to Community Supports that will help the pregnant or postpartum individual as they prepare for or recover from labor and delivery, including housing and food-related Community Supports.

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[48] At this time, BIH Program, CPEI, and AIMSS do not have detailed care management plans that are established for Members enrolled in the program.

- Coordinating the transition from hospital to home after labor and delivery and with various health and social services providers, including sharing data (as appropriate), to facilitate better-coordinated whole-person care.
- Supporting Member treatment adherence, including scheduling prenatal and postpartum appointments and well-child visits, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Connecting the pregnant or postpartum individual, their partner, and/or their family with resources regarding the Member's conditions to assist them with providing support for the Member's health and newborn or infant's health, including but not limited to facilitating referral for Members and their families to home and community supports for early childhood, such as county First 5s.
- Coordinating care across all applicable delivery systems (Medi-Cal Managed Care or Medi-Cal FFS; SMHS; DMC or DMC-ODS; Dental Managed Care or Dental FFS; and Medi-Cal Rx) and care coordinators.

Community Supports:

MCPs are strongly encouraged to offer Community Supports to Members who enroll in ECM under this Population of Focus.[49] Doing so can enhance care and prevent costly and unnecessary hospitalizations. Each Member will have different needs and functional limitations. Below are a few examples of Community Supports that may be particularly beneficial:

- Housing Transition Navigation Services.
- Housing Deposits.
- Housing Tenancy and Sustaining Services.
- Transitional Rent.
- Medically Tailored Meals/Medically-Supportive Food.

[49] For the comprehensive menu of Community Supports services and their corresponding service definitions, refer to the Community Supports Policy Guide, Volume I (non-housing) and Volume II (housing).

Provider Contracting (Updated January 2026):

MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve. Please refer to Section VII. ECM Provider Network below for more information.

There are no limitations on who can be an ECM Provider for this Population of Focus. There are natural fits on who this Provider type could be to best support pregnant and postpartum individuals, such as OB/GYNs (Obstetrics /Gynecology), Family Medicine Physicians, Midwives, Doulas, Community Health Representatives (CHRs), or Promotoras. There are also existing California programs that support pregnant and postpartum individuals including home visiting programs, [50] [51]CPSP, BIH Program, PEI, Indian Health Program, AIMSS, county behavioral health programs, local WIC agencies, and CBOs supporting individuals experiencing intimate partner violence. Given these programs' perinatal expertise, MCPs should conduct outreach to these programs to encourage them to serve as an ECM Provider and support pregnant and postpartum individuals already receiving care through these programs in order to receive additional support, as needed, through ECM (see Section VI. Program Overlaps and Exclusions).

DHCS has recently introduced a Doula benefit in Medi-Cal. Members receiving doula services who also qualify for ECM are not be precluded from receiving ECM as long as the MCP ensures that Providers do not receive duplicative reimbursement for the same services provided to the same Member. Doula services are available to any birthing individual in Medi-Cal, whereas ECM eligibility is limited to a qualifying Population of Focus. Doulas and ECM Care Coordinators are envisioned to have separate and distinct roles, though if eligible (see Section VII. ECM Provider Network), doulas are welcome to contract with MCPs as ECM Providers. To learn more about DHCS' new Medi-Cal covered doula benefit, see the DHCS Doula Services webpage.

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[50] CDPH operates the California Home Visiting Program (CHVP) and provides infrastructure, support, and funding for evidence-based home visiting programs statewide. As of December 2022, CHVP has approved three evidence-based home visiting models: Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). See more on these programs here.

[51] CDSS operates the CalWORKs Home Visiting Program (HVP) and provides infrastructure and supervision, with administration provided by participating California counties. CDSS permits counties to adopt HVPs that align with the U.S. HHS' evidence-based home visiting requirements.

V. CORE SERVICE COMPONENTS OF ECM

A. Overview of ECM Core Service Components

The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social needs, and long-term services and supports for Members, including participating in the care planning process, regardless of setting. ECM activities should become integrated with other care coordination processes and functions, and in most cases, the ECM Provider must assume primary responsibility for coordination of the Member's needs, including collaboration with other coordinators who operate in a more limited scope.

ECM is intended to be interdisciplinary, high touch, person centered and provided primarily through in-person interactions with Members where they live, seek care and prefer to access services. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. It will be critical for ECM Providers to establish strong relationships with these Members (and their parent, caregiver, guardian if applicable), and this will occur most effectively through in-person interactions in locations most convenient for the Member. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider is permitted to use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice. As the managed care benefit becomes more established, DHCS will be interested, in the course of its monitoring, in understanding the efficacy between ECM Provider location-based in-person interactions vs. community/home-based interactions.

This section describes the seven ECM core services. The core components of ECM that are universal for all Populations of Focus include (1) Outreach and Engagement; (2) Comprehensive Assessment and Care Management Plan; (3) Enhanced Coordination of Care; (4) Health Promotion; (5) Comprehensive Transitional Care; (6) Member and Family Supports; and (7) Coordination of and Referral to Community and Social Support Services. Notably, the nuances of supports and services provided through ECM will vary based on the needs of the Member. The ECM provider is expected to provide all of the services as enumerated and not only a subset of these services.

1. Outreach and Engagement

MCPs are responsible for identifying (or accepting referrals for) Members who are eligible for ECM. MCPs will then assign every Member authorized for ECM to an ECM Provider. ECM Providers are responsible for reaching out to, and engaging, assigned Members. DHCS will be monitoring rates of ECM penetration for each Population of Focus as a key marker of the managed care benefit's efficacy; MCPs should track key performance indicators to ensure that Member outreach and engagement strategies do not perpetuate health disparities and, in fact, help address disparities by race, ethnicity, Healthy Places Index, and other factors. This monitoring and oversight approach is aligned with the State's approach broadly with the CalAIM Program, as well as the Incentive Payment Program (IPP).

MCPs must develop comprehensive outreach Policies and Procedures as part of the MOC. Activities in the Outreach and Engagement core service can include, but are not limited to:

a. Attempting to locate, contact and engage Members (and/or their parent, caregiver, guardian) who have been identified as good candidates to receive ECM services, promptly after assignment.
b. Using multiple strategies for engagement, as appropriate and to the extent possible, including direct communications with the Member (and/or their parent, caregiver, guardian), such as in-person meetings where the Member lives, seeks care or is accessible; mail, email, texts and telephone; community and street-level outreach; follow-up if the Member presents to another partner in the ECM network; or using claims data to contact Providers the Member is known to use.
c. Using an active and progressive approach to outreach and engagement until the Member (and/or their parent, caregiver, guardian) is engaged.
d. Documenting outreach and engagement attempts and modalities.
e. Utilizing educational materials and scripts developed for outreaching and engaging Members, as appropriate.
f. Sharing information between the MCP and ECM Providers, to ensure that the MCP can assess Members for other programs if they cannot be reached or decline ECM.
g. Providing culturally and linguistically appropriate communications and information to engage Members (and/or their parent, caregiver, guardian) and

ensuring that such approaches build trust with communities that have historically been underserved in the Medi-Cal program.

2. Comprehensive Assessment and Care Management Plan

After the initial step of successful engagement with an ECM Member, a comprehensive assessment should be conducted and a care plan developed. As part of the assessment, MCPs must include DHCS standardized LTSS referral questions [52] to identify and refer Members who may have LTSS needs, unless the Member has already answered these questions. This process involves the ECM Members (and their parent, caregiver, guardian) as well as appropriate clinical input in developing a comprehensive, individualized, person-centered care plan. The care plan is based on the needs and desires of the Member and should be reassessed based on the Member's individual progress or changes in their needs and/or as identified in the care plan. The care plan must incorporate the Member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. Comprehensive care management may include case conferences to ensure that the Member's care is continuous and integrated among all service Providers.

Activities in the Comprehensive Assessment and Care Management Plan core service must include, but are not limited to:

a. Engaging with each Member (and/or their parent, caregiver, guardian) authorized to receive ECM primarily through in-person contact.

b. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member (and/or their parent, caregiver, guardian) choice.

c. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.

d. Developing a comprehensive, individualized, person-centered care plan with input from the Member (and/or their parent, caregiver, guardian) as appropriate to prioritize, address, and communicate strengths, risks, needs, and goals. The

[52] Current LTSS questions are those established in APL 17-013 or superseding APL.

care plan must also leverage Member strengths and preferences and make recommendations for service needs.

e. In the Member's care plan, incorporating identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care,

f. necessary community-based and social services, and housing.

g. Ensuring the Member is reassessed at a frequency appropriate for the Member's individual progress or changes in needs as determined in collaboration with the ECM Provider, and/or as identified in the Care Management Plan. **DCHS does not require an annual reassessment for Members**. **Rather, DHCS requires that MCPs ensure each Member is reassessed at a clinically appropriate frequency.** The need for reassessment should be balanced with associated administrative burden for ECM Providers. MCPs should avoid imposing blanket reassessment timeframes and should instead consider the use of other tools, including data sharing and chart audits, to maintain visibility on care plans and Member progress.

h. Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

3. Enhanced Coordination of Care

Enhanced Coordination of Care includes the services necessary to implement the care plan. Enhanced Coordination of Care services must include, but are not limited to:

a. Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan.

b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs. Further, in alignment with the PHM BPHM requirements, the assigned ECM Lead Care Manager is responsible for ensuring that the Member has an assigned PCP and that they are engaging with that PCP for appropriate care. Enhanced Coordination of Care may include case conferences in order to ensure that the Member's care is continuous and integrated among all service Providers.

c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.

d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.

e. Communicating the Member's needs and preferences in a timely manner to the Member's multi-disciplinary care team in an effort to ensure safe, appropriate and effective person-centered care.

f. Ensuring regular contact with the Member (and/or their parent, caregiver, guardian) when appropriate, consistent with the care plan and to ensure information is shared with all involved parties to monitor the Member's conditions, health status, care planning, medications usages and side effects.

4. Health Promotion

As established in the PHM Policy Guide the assigned ECM Lead Care Manager is responsible for ensuring that BPHM is in place as part of the Members' care management. [53] BPHM includes Health Promotion services to encourage and support Members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health. Health Promotion services can include, but are not limited to:

a. Working with Members to identify and build on successes and potential family and/or support networks.

b. Providing services, such as coaching, to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health.

c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

[53] See the PHM Policy Guide Section E. Providing PHM Program Services & Supports.

d. Linking Members to resources for smoking cessation, management of Member chronic conditions, self-help recovery resources and other services based on Member needs and preferences.

e. Using evidence-based practices, such as motivational interviewing, to engage and help the Member participate in and manage their care.

5. Transitional Care Services

Transitional Care Services include services intended to support Members and their families and/or support networks as Members transfer from one setting or level of care to another, including, but not limited to discharges from hospitals, institutions, other acute care facilities, and SNFs to home- or community-based settings, Community Supports, post-acute care facilities, or LTC settings. Services include supporting Members' transitions from discharge planning until they have been successfully connected to all needed services and supports. Additionally, ECM Providers should provide information to the hospital discharge planners or discharging facility staff about ECM so that collaboration on behalf of the Member can occur in as timely a manner as possible and that the member does not receive two different discharge planning documents. Transitional Care Services can help avoid unnecessary readmissions. Transitional Care Services include, but are not limited to:

a. Knowing, in a timely manner, each Member's admission, discharge, or transfer to or from an ED, hospital inpatient facility, SNF, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members. MCPs are responsible for ensuring that ECM Providers have access to or are provided ADT feed data information for enrolled Members to provide transitional care services for ECM Members.

b. Developing strategies to reduce avoidable Member admissions and readmissions. Examples include ensuring timely prior authorizations and discharges, establishing agreements and processes to promptly notify to the Member's Lead Care Manager, who will ensure all Transitional Care Services are complete, including but not limited to: ensuring discharge risk assessment and discharge planning document is created and shared with appropriate parties; planning timely scheduling of follow-up appointments with recommended outpatient Providers and/or community partners; conducting medication reconciliation or Closed Loop Referrals, developing policies to arrange transportation for transitional care, including to medical appointments, as per

Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures; and easing the Member's transition by addressing their understanding of rehabilitation activities, self- management activities and medication management.

c. For Members who are experiencing or are likely to experience a care transition, the ECM Lead Care Manager is responsible for:

   i. Developing and regularly updating a discharge planning document for the

   ii. Member; this includes facilitating discharge instructions developed by a

   iii. hospital discharge planner or discharge facility staff.

   iv. Ensuring the completion of discharge risk assessment and coordinating any follow up provider appointments and support services to facilitate safe and appropriate transitions from one setting or level of care to another.

   v. Coordinating medication review/reconciliation.

   vi. Providing adherence support and referral to appropriate services.

For more information about transitional care more broadly (for those in and not in ECM), refer to the PHM Policy Guide, Section E. Providing PHM Program Services and Supports: c. Transitional Care Services.

6. Member and Family Supports

Member and Family Supports include activities that ensure the ECM Member and family/support are knowledgeable about the Member's conditions, with the overall goal of improving their adherence to treatment and medication management. Member and Family Supports could include, but are not limited to:

a. Documenting a Member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their Member's authorized parent, caregiver, guardian, other family member(s) and/or other authorized support person(s), as applicable.

b. Conducting activities to ensure the Member and/or parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment,

and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

c. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or parent, caregiver, guardian, other family member(s) and/or other authorized support person(s)

d. Identifying supports needed for the Member and/or their parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) to manage the Member's condition and assist them in accessing needed support services and assist them with making informed choices.

e. Providing for appropriate education of the Member parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) about care instructions for the Member.

f. Ensuring that the Member parent, caregiver, guardian, other family member(s) and/or other authorized support person(s) has a copy of his/her care plan and information about how to request updates.

7. Coordination of and Referral to Community and Social Support Services

Coordination of and Referral to Community and Social Support Services involves determining appropriate services to meet the needs of Members receiving ECM, to ensure that any present or emerging social factors can be identified and properly addressed. Coordination of and Referral to Community and Social Support Services could include, but are not limited to:

a. Determining appropriate services to meet the needs of Members, including services that address SDOH needs, including housing, and services offered by Contractor as Community Supports.

b. Coordinating and referring Members to available community resources and following up with Members (and/or parent, caregiver, guardian) to ensure services were rendered (i.e., "closed-loop referrals").

VI. PROGRAM OVERLAPS AND EXCLUSIONS

ECM will coordinate all care for the highest-risk Members with complex medical and social needs, including across the physical and behavioral health delivery systems.

For ECM Members, the ECM Lead Care Manager serves as the key individual who identifies the need for additional services (e.g. Community Supports, food and nutrition resources, early childhood services), places referrals, and coordinates services, all while coordinating the Member's broader clinical and nonclinical care. The ECM Lead Care Manager must know every component of the Member's needs and services and ensure that they are coordinated.

Many Members who will be eligible for ECM may already be receiving some care management through other programs. In many of these instances, ECM managed care benefit will be additive, improve management of care across delivery systems, and comprehensively address any unmet medical and/or social needs. DHCS has determined three approaches for how ECM may overlap with existing programs that provide care management/care coordination services. Below is a summary of the programs that have been considered and the three potential approaches.

Figure 2: Summary Of Approaches to ECM Overlaps/Non Duplication (Updated September 2026)

Category	Other Programs	Enrolled in both ECM and the other program	Enrolled in either ECM or the other program	Not eligible to enroll in ECM
1915(c) Waivers	Multipurpose Senior Services Program (MSSP)		✓	
	Assisted Living Waiver (ALW)		✓	
	Home and Community-Based Alternatives Waiver (HCBA)		✓	
	Medi-Cal Waiver Program (formerly the HIV/AIDS Waiver)		✓	
	HCBS Waiver for Individuals with Developmental Disabilities (I/DD) (HCBA-DD)		✓	

Category	Other Programs	Enrolled in both ECM and the other program	Enrolled in either ECM or the other program	Not eligible to enroll in ECM
	Self-Determination program for Individuals with I/DD		✓	
Services Carved out of Managed Care	California Children's Services (CCS) in Classic Counties (i.e., not Whole Child Model)	✓		
	County based Targeted Case Management (TCM)			✓
	Specialty Mental Health Services (SMHS) Targeted Case Management (TCM)	✓		
	SMHA Intensive Care Coordination for Children (ICC)	✓		
	Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal (DMC) Care Coordination & Management Programs	✓		
	Full Service Partnership (FSP)	✓		
	Health Care Program for Children in Foster Care (HCPCFC)	✓		
	In Home Supportive Services (IHSS)	✓		
	Genetically Handicapped Person's Program (GHPP)	✓		
Services Carved into Managed Care	CCS Whole Child Model (WCM)	✓		

Category	Other Programs	Enrolled in both ECM and the other program	Enrolled in either ECM or the other program	Not eligible to enroll in ECM
	Managed Care Plan Complex Care Management (CCM)		✓	
	Community-Based Adult Services (CBAS)	✓		
Health Plans and Programs for Dual Eligible Members	Dual Eligible Special Needs Plan (D-SNP)			✓
	Medicare Advantage plan (not D-SNP)	✓		
	Original Medicare	✓		
	Program of All-Inclusive Care for the Elderly (PACE)			✓
	If in any other excluded program (e.g. 1915c or CCT program), regardless of Original Medicare or Medicare Advantage enrollment		✓	
Other Programs	California Community Transitions (CCT) Money Follows the Person (MFTP)		✓	
	Hospice			✓
	California Wrap Around	✓		

Category	Other Programs	Enrolled in both ECM and the other program	Enrolled in either ECM or the other program	Not eligible to enroll in ECM
	Regional Center Program	✓		
Programs Serving Pregnant and Post-Partum Individuals	Comprehensive Perinatal Services Program (CPSP)	✓		
	Black Infant Health (BIH) Program	✓		
	California Perinatal Equity Initiative (PEI)	✓		
	Indian Health Program/American Indian Maternal Support Services (AIMSS)	✓		
	CHPH Home visiting program (CHVP)	✓		
	CDSS CalWORKs Home Visiting Program (HVP)	✓		

Ultimately, MCPs are responsible for ensuring non-duplication of services provided through ECM and any other program(s). As such, MCPs should regularly check available data feeds to evaluate which of their Members might be enrolled in other programs that provide care coordination. In addition, MCPs should establish processes and requirements to ensure ECM Providers ask Members about their participation in other programs as part of the in-person comprehensive assessment and care planning process. If ECM is being provided in addition to an existing care management program, the existing program must not be discontinued.

The section below offers additional guidance about the relationship between ECM and the other programs.

A. 1915(c) Waiver Programs

California has six 1915(c) waivers, including Multipurpose Senior Services Program (MSSP), Assisted Living Waiver (ALW), Home and Community-Based Alternatives (HCBA) Waiver, Medi-Cal Waiver Program (MCWP) (formerly HIV/AIDS Waiver), HCBS Waiver for I/DD (HCBA-DD), Self-Determination Program for Individuals with I/DD.

Adult, child, and youth MCP Members can be enrolled in ECM or in a 1915(c) waiver program, not in both at the same time.

- 1915(c) waiver programs provide services to many Medi-Cal Members who will likely also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).
- There are comprehensive care management components within the 1915(c) waiver programs that are duplicative of ECM services.
- As such, Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving ECM services.
- Members who are on a wait list for a 1915(c) waiver program are likely good candidates to receive ECM until a slot in a 1915(c) waiver program becomes available.
- If a Member is receiving ECM and then a slot to enroll in a 1915(c) waiver program becomes available, the MCP should ensure that the Member has the choice of whether they will continue receiving ECM or enroll in the 1915(c) waiver program.
- The MCP should provide education to the Member about their options, including describing what is available through ECM managed care benefit compared with 1915(c) waiver programs, so the Member can make an informed decision.

B. Services Carved Out of Managed Care

1. California Children's Services (CCS):

Child and youth MCP Members can be enrolled in ECM and CCS. ECM enhances and/or coordinates across the case/care management available in CCS. MCP must ensure non-duplication of services between ECM and CCS.

- CCS is a joint statewide program administered by DHCS and county health departments and is "carved out" of the broader Medi-Cal program. Children and youth enrolled in CCS (up to 21 years old) with CCS-eligible medical conditions receive diagnostic and treatment services, medical case management, physical and occupational therapy, and authorized medical equipment.
- Each CCS Member is supported by a paneled core team consisting of: Medical Director/Physician, SCC Coordinator, Registered Nurse, Medical Social Worker, and Registered Dietitian. The qualifications and responsibilities of each team member can be found in the CCS Manual of Procedures.
- CCS medical case management service components include:
    - Intake: Conducting health and psychosocial assessment; developing care plan (including required coordination across organizations) and social work plan.
    - Ongoing treatment and patient follow–up: Conducting periodic reassessments; coordinating, referring, and monitoring all services and follow ups as outlined in the patient care plan; convening team conferences to coordinate decision making and delivery of health care services.
    - Patient and family teaching: Soliciting family (and child when mature enough) participation and collaboration in plan of care; providing education to parents and family members about the system of care and services (including social services) available.
    - Multidisciplinary comprehensive team assessments: Maintaining documentation of assessments/reassessments and medical emergency plan.
    - Transition support: Planning for the transition of youth to adult services by the age of 14 including sources of medical, vocational, financial, and support services and safety planning for youth with disabilities.
- ECM enhances, but does not displace, CCS. MCPs are expected to work with local county CCS offices to ensure that Members receiving ECM services do not receive duplicative CCS services. Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective MOC.
- For more information on CCS, see the CCS Manual of Procedures (Chapter 3.37: Provider Core Standards), DHCS' Information About CCS Brief, DHCS' CCS

Program Overview webpage, and DHCS' CCS Medical Therapy Program webpage.

2. County-Based Targeted Case Management (TCM)[54] (Updated September 2026)

Until June 30, 2024, adult, child, and youth MCP Members who qualify for both ECM and County-based TCM can be enrolled in both programs. **Beginning July 1, 2024, Members who meet ECM POF criteria should be enrolled in ECM and may no longer be enrolled in ECM and County-based TCM programs at the same time except for a one-year exception from July 1, 2024 to June 30, 2025 for cases where the Member is receiving County-based TCM (1) for addressing a communicable disease or (2) for the sole purpose of receiving a home visiting program supporting the healthy development and well-being of children and families, as described further below.** Until that time, ECM may enhance and/or coordinate across the case/care management available in County-based TCM. This change is being made consistent with the fact that virtually all Medi-Cal beneficiaries will be served in the Managed Care delivery system by 2024. By making ECM available for MCP Members, DHCS is intentionally aiming to promote comprehensive care management while reducing the number of different care managers involved in managing a Member's care.

- The TCM program is an optional Medi-Cal program funded by federal and local funds, serving approximately 13,000 Medi-Cal beneficiaries each year across 5 target populations. TCM became a covered Medi-Cal benefit effective January 1, 1995 and provides comprehensive case management services to eligible Medi-Cal Members of defined targeted populations. TCM reimburses local governmental agencies (LGAs) for the federal share of costs (typically 50%) for case management services, with DHCS administering reimbursement.
- Most Medi-Cal beneficiaries who qualify for County-based TCM will also qualify for ECM once all ECM Populations of Focus are live in 2024.
- DHCS' expectations for coordination between programs **prior to July 1, 2024** are as follows:
    - MCPs are responsible for analyzing whether TCM is duplicative of ECM at the county program level and at the Member level.

[54] County-based TCM is distinct from TCM provided as a component of SMHS, which is covered below.

- ECM can be additive to TCM **where TCM is not comprehensive** (e.g., in a county that offers specific homelessness interventions via TCM but without coordination of other health and social needs).
- If an MCP determines that the TCM **is comprehensive** and therefore substantially duplicative of ECM, the MCP must ensure that individuals do not receive both in that county.
- MCPs are expected to work with Local Governmental Agencies (LGAs) to ensure that Members receiving ECM services do not receive duplicative TCM services.

» DHCS' expectations **from July 1, 2024 onward** are as follows**:**

- **General rule of no dual enrollment between ECM and County- based TCM:** For MCP Members who are identified as eligible for both County-based TCM and ECM:
  - ECM should be the first option for comprehensive care management. All Members who meet ECM Population of Focus criteria should be referred to the Member's MCP for ECM authorization. The LGA is encouraged to become an ECM Provider under contract with the MCP, and MCPs are encouraged to contract with LGAs as ECM Providers. DHCS will continue to assess
  - MCPs' ECM networks for adequacy and inclusion of LGA providers.
  - County-based TCM providers may continue providing TCM to the small number of Members who are eligible for TCM but ineligible for ECM such as adults and youth who are pregnant and postpartum who qualify for County-based TCM and are not eligible for the ECM Birth Equity POF, or children and youth who qualify for County-based TCM and are not eligible for the ECM Children and Youth POFs.
  - MCPs are strongly encouraged to contract with current County-based TCM providers who are becoming ECM Providers.

3. Specialty Mental Health Services (SMHS) Targeted Case Management (TCM):

MCP Members receiving SMHS TCM from counties can also be eligible for and receive ECM services. MCPs are required to work with counties to identify Members receiving SMHS TCM and ensure non-duplication of services.

- Counties administer the SMHS program, which is "carved out" of the broader Medi-Cal program under the authority of a 1915(b) waiver approved by CMS. The SMHS waiver program is administered locally by each county's MHP, and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries, including SMHS TCM and Peer Supports.
- SMHS TCM encompasses services that assist a beneficiary to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include: communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development. TCM includes the following assistance:
    - Comprehensive assessment and periodic reassessment (annual basis or shorter as appropriate) of individual needs to determine the need for
    - establishment of TCM services to access any medical, educational, social, or other services.
    - Development and periodic revision of client plan.
    - Referral and related activities to help an eligible individual obtain needed services including activities that help an individual with medical, alcohol and drug treatment, social, educational Providers or other programs and services that are capable of providing needed services.
    - Monitoring and follow up activities that are necessary to ensure the Client Plan is implemented and adequately addresses the individual's needs.

      Further information about SMHS TCM services can be found under State Plan Supplement 1 to Attachment 3.1-A – Targeted Case Management (TCM) Services for Medi-Cal Beneficiaries that Meet Medical Necessity Criteria for TCM Covered as Part of the Specialty Mental Health Services Program (2012).

4. SMHS Intensive Care Coordination (ICC) for Children

Child and youth MCP Members can both be enrolled in ECM and receive SMHS ICC. ECM enhances ICC and coordinates across the case/care management available in SMHS ICC. The MCP is required to work with the county to ensure non-duplication of services between ECM and SMHS ICC.

- SMHS ICC is a statewide intensive form of SMHS TCM (see above) that facilitates the assessment of, care planning for, and coordination of services for children and youth with more intensive needs who are in or at risk of placement in residential or hospital settings, but could be effectively served in the home and community.
- SMHS ICC service components include:[55]
    - Planning and assessment of strengths and needs: The ICC coordinator is responsible for working within the CFT to ensure that plans from any of the system partners (MHPs, child welfare, juvenile, probation, education, etc.) are integrated to comprehensively address the identified goals and objectives.
    - Reassessment of strengths and needs: The ICC Coordinator and the CFT should reassess the strengths and needs of children and youth and
    - their families, at least every 90 days, and as needed.
    - Referral, monitoring and follow up activities: The ICC coordinator conducts referral, linkages, monitoring, and follow up activities, to ensure that the child's/youth's needs are met.
    - Transition: When the child or youth has achieved the goals of his/her client plan, the CFT should engage in developing a transition plan for the child/youth and family, to promote long-term stability.
- For Members receiving both ECM and ICC, ECM Providers work closely with the ICC coordinator and any other care management providers for the Member to organize the CFT and coordinate care across all care management programs and systems. ECM Providers are encouraged to reach out the ICC coordinator to define roles and responsibilities for the Member.

[55] Refer to Medi-Cal Manual For ICC (January 2018) for more information about SMHS ICC program and services provided.

5. Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal (DMC) Care Coordination & Management Programs

Adult, child, and youth MCP Members can be enrolled in both ECM and receive DMC-ODS/DMC services. ECM enhances the DMC-ODS/DMC care coordination available and coordinates across the DMC-ODS/DMC Program and other services. MCP must ensure non-duplication of services between ECM and the DMC-ODS/DMC Program.[56]

- Care coordination for the DMC-ODS delivery system is provided to patients in conjunction with all levels of SUD treatment and consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care coordination includes one or more of the following components: [57]
  - Coordinating with medical and mental health care Providers to monitor and support comorbid health conditions.
  - Discharge planning, including coordinating with SUD treatment Providers to support transitions between levels of care and to recovery resources, referrals to mental health Providers, and referrals to primary or specialty medical Providers.
  - Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child care, child development, family/marriage education, cultural sources, and mutual aid support groups.

6. Full Service Partnership (FSP) (Funded by Mental Health Services Act (MHSA))

Counties who are ECM Providers can deliver ECM to individuals who are also enrolled in an FSP program. MCPs may not exclude Members from ECM because they are FSP

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[56] Refer to Appendix E for an overview of counties participating in the DMC- ODS/DMC Programs.

[57] Additional information about DMC-ODS services can be found in BHIN 24-001: DMC-ODS Requirements for the Period of 2022-2026 or superseding BHIN.

program participants. MCPs and counties that oversee the MHSA funded FSP programs must work together to share data and identify Medi-Cal managed care adult, child, and youth Members served by both programs and ensure non-duplication of services and funding between ECM and FSP programs.

Counties also have discretion to prioritize FSP program slots for individuals not eligible for ECM (e.g., because they are not Medi-Cal MCP Members, or they do not meet ECM Population of Focus criteria).

7. Health Care Program for Children in Foster Care (HCPCFC)

Child and youth MCP Members can be enrolled in ECM and HCPCFC. ECM enhances and/or coordinates across the case/care management available in HCPCFC. MCP must ensure non-duplication of services between ECM and HCPCFC.

- HCPCFC is a statewide public health nursing program that provides care management and coordination of medical, dental, developmental, and behavioral health for foster children, probation youth, and non-minor dependents.
- HCPCFC is currently administered by a partnership with DHCS, CDSS, and county health departments under the Child Health Disability Prevention (CHDP) program.
    - CHDP will sunset by July 1, 2024. DHCS has started the transition of moving HCPCFC into a stand-alone program. HCPCFC will *not* sunset with CHDP.
- HCPCFC service components include:
    - Care planning: Evaluation of available information regarding physical, dental, developmental, and behavioral health; child welfare history; family history; and other social factors affecting the child's/youth's health. Development of a care plan which is shared with the youth's assigned case worker and substitute caregiver(s) as appropriate.
    - Ongoing care management and follow-up: Conducting periodic reassessments; psychotropic medication monitoring and oversight, coordinating, referring, and monitoring services and follow ups as applicable; Revising the care plan to reflect reassessment; Communicating progress with the assigned case worker and/or caregiver(s) as appropriate.

- Patient and family teaching: Soliciting family (and child when mature enough) participation and collaboration in plan of care; providing education to caregivers to support the objectives described in the plan of care.
- Care coordination: Facilitating the completion of the objectives identified in the plan of care.

» ECM can be provided in addition to services provided by HCPCFC. MCPs are expected to work with local county HCPCFC management (Public Health, Health and Human Services depending on the jurisdiction) to ensure that Members receiving ECM services do not receive duplicative HCPCFC services. Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective MOCs.

8. In Home Supportive Services (IHSS)

Adult MCP Members who receive IHSS services are also eligible for ECM if they meet the ECM Population of Focus criteria.

9. Genetically Handicapped Person's Program (GHPP)

Adult MCP Members can be enrolled in ECM and the GHPP. ECM enhances and/or coordinates across the case/care management available in the GHPP. MCP must ensure non-duplication of services between ECM and the GHPP.

» There are approximately 1,500 individuals enrolled in the GHPP across the state; approximately 650 of them are also enrolled in Medi-Cal Managed Care.

» MCP Members participating in the GHPP can also receive ECM, so long as they also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).

C. Services Carved into Managed Care

1. CCS Whole Child Model (WCM)

Child and youth MCP Members can be enrolled in ECM and CCS WCM. ECM enhances a child and youth's care coordination and fills the gaps across the case/care management provided by CCS WCM while reducing the navigational burden for families and children

needing services beyond these from other Providers. MCP must ensure non-duplication of services between ECM and CCS WCM.

- CCS WCM is operated by MCPs in select counties, integrating Medi-Cal Managed Care and county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in primary, specialty, and behavioral health for CCS-eligible and non-CCS eligible conditions. CCS WCM is "carved-in" to the broader Medi-Cal Managed Care program.
- CCS WCM service components for medical case management include:
  - Screening and referrals: MCPs must refer potential CCS-eligible Members to county CCS program for CCS eligibility determination.
  - Risk level and needs assessment: MCPs must assess each CCS Member's risk level and needs by performing a pediatric risk assessment process (PRSP) to classify Members into high and low risk categories. MCPs must reassess a Member's risk level and needs annually at the CCS eligibility determination or upon a significant change to a Member's condition.
  - Members identified as high risk through the PRSP must be further assessed by telephonic and/or in-person communication or a risk assessment survey within 90 calendar days of enrollment to assist in the development of an ICP.
    - The risk assessment must address general health status and recent health care utilization, health history, specialty Provider referral needs, prescription medication utilization, specialized or DME needs, need for specialized therapies, limitation of ADLs or daily functioning, as well as demographics and social history.
    - The ICP must, at a minimum, include medical (primary care and CCS specialty) services, mental health (non-specialty mental health and/ or county SMHS) services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, SUD (DMC-ODS or DMC) services, home health services, Regional Center services, and other medically necessary services.
  - Case management and care coordination: MCPs must provide case management and care coordination across the health care systems, including transitions among levels of care and interdisciplinary care teams. Care coordination also includes referrals to sub–specialists and

other services identified in the Member's ICP. MCPs must also ensure that information, education, and support is continuously provided to CCS-eligible Members and their families.

- Maintenance and transportation: MCPs must provide support for transportation and associated costs (e.g., meals, lodging) for family seeking transportation to a medical service related to their CCS-eligible condition.

» Refer to Appendix F for an overview of counties participating in the CCS WCM and to APL 23-034 or superseding APL for all requirements of MCPs participating in the CCS WCM program.

» ECM can be provided in addition to WCM. MCPs are expected to ensure that Members receiving ECM services do not receive duplicative CCS WCM services. Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective MOC. Where it is appropriate, CCS WCM elements can be delegated to ECM Providers to ensure children and youth receive comprehensive, non-duplicated care across ECM and CCS WCM.

» For more information on CCS WCM, see the APL 23-034 or superseding APL, CCS WCM FAQs, and DHCS' CCS WCM webpage.

2. Complex Care Management (CCM)

Effective January 1, 2023, MCPs will also be required to provide Complex Care Management (CCM) program and services under the PHM Program.[58] See Figure 1 in Section II above outlining the CalAIM Care Management Continuum.

CCM is a service for higher- and medium-rising-risk MCP Members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability in the right setting and in a cost-effective manner. MCPs are already required to provide CCM. MCPs will continue to be required to

[58] MCPs are still required to offer Basic and Complex Case Management for Medi-Cal Managed Care Members until January 1, 2023, when the PHM Program requirements are effective. Refer to Medi-Cal Managed Care Contract, Exhibit A, Attachment 11, Provision 1. Comprehensive Care Management Including Coordination of Care Services.

provide CCM in 2023, in line with the requirement that all MCPs must meet the NCQA PHM standards on January 1, 2023.

Following the Amended 2023 MCP Contract and in line with NCQA's requirements, MCPs must comply with the following requirements:

- MCPs are allowed to determine their own eligibility criteria (within NCQA guardrails[59]) based on the risk stratification process and local needs identified in the Population Needs Assessment (PNA) required under the PHM Program.
- CCM must include a comprehensive assessment, a Care Management Plan, and a variety of interventions to meet the differing needs of high and medium-/rising-risk populations, such as care coordination for longer-term chronic conditions or disease-specific management programs.
- MCPs must also assign a care manager for every Member receiving CCM to ensure all BPHM requirements and NCQA CCM standards are met. MCPs must provide the Member's PCP with the identity of a Member's assigned care manager (if the PCP is not assigned to this role) and a copy of the Member's Care Management Plan.

For children and youth under age 21, CCM must include EPSDT; all medically necessary services, including those that are not necessarily covered for adults, must be provided as long as they could be Medicaid-covered services.

MCPs must consider CCM to be an opt-out program – (i.e., Members may choose not to participate in CCM if it is offered to them), and MCPs may delegate CCM to Providers and other entities who are themselves NCQA-certified.

For more information about CCM, Refer to the PHM Policy Guide, Amended 2023 MCP Contract, and DHCS' CalAIM PHM webpage.

3. ECM and CCM Overlap Policy and Delegation

An individual cannot be enrolled in ECM and CCM at the same time; rather, CCM is on a care management continuum with ECM. CCM can be used to support Members who were previously served by ECM, are ready to step down, and who would benefit from CCM; but not all Members in CCM previously received ECM, and not all Members who

[59] See NCQA 2021 Health Plan Accreditation PHM Standards. PHM 5: Complex Case Management.

step down from ECM require CCM. DHCS encourages MCPs to work with Providers to contract for a care management continuum of ECM and CCM programs, wherever possible, including as a way to maximize opportunities for Members to step down from ECM to CCM or BPHM under the care of a single Provider.

4. Community-Based Adult Services (CBAS)

Adult MCP Members can be enrolled in ECM and CBAS. ECM enhances and/or coordinates across the case/care management available in CBAS centers. MCP must ensure non-duplication of services between ECM and CBAS centers.

- CBAS and ECM services are complementary.
- ECM can offer comprehensive care management beyond the services provided through CBAS, which are primarily provided within the four walls of the CBAS center.
- Given their connection to community resources, CBAS centers may also be well positioned to serve as ECM Providers.
- If an individual is enrolled in both ECM and CBAS, and their CBAS Provider is a contracted ECM Provider, the MCP should assign that CBAS Provider to be the Member's ECM Provider, unless the Member prefers a different ECM Provider.

D. Dual Eligible Members (Updated September 2026)

Members dually eligible for Medicare and Medi-Cal may be eligible for ECM through their Medi-Cal MCP if they meet the applicable Population of Focus criteria, and if they are **not** enrolled in any of the plans/programs listed below, as these plans/programs offer comprehensive care management that is duplicative of ECM services:

- Dual Eligible Special Needs Plans (D-SNPs), which include Medi-Medi Plans, SCAN Fully Integrated D-SNP (FIDE-SNP), and all other D-SNPs;
- Program of All-Inclusive Care for the Elderly (PACE); and
- Any other excluded programs (e.g., 1915(c) waivers, CCT).

For dual eligible Members eligible for ECM and enrolled in a D-SNP, DHCS recognizes there is significant overlap across the D-SNP Model of Care (MOC) and ECM requirements, which could result in duplication and confusion for Members and care teams if a Member receives care management from both programs. Member care management is a primary function of D-SNPs.

Since January 1, 2026, all D-SNPs are required to provide California Integrated Care Management (CICM) to eligible Members. CICM is very similar to ECM, and builds upon a federally required care management program for D-SNP members. Plans can refer to the DHCS CalAIM D-SNP Policy Guide webpage for CICM requirements. The Care Coordination chapter of the D-SNP Policy Guide reflects the intent for D-SNPs to provide sufficient care management so that Members who would otherwise qualify for ECM through their MCP receive an equivalent level of care coordination through their D-SNP.[60]

For Members who join a D-SNP and are already receiving Medi-Cal ECM from their MCP, D-SNPs shall provide ongoing continuity of care with existing Medi-Cal ECM providers, when possible, for up to 12 months. A D-SNP may offer a longer continuity of care period, but it is not required.

Figure 3: Overview of ECM Eligibility for Dual Eligible Members (Updated September 2026)

Medicaid & Medicare Delivery Model[61]	ECM Eligible
FIDE-SNPs	**No (b/c CICM provided)**
PACE Programs	**No (b/c similar provided)**
Medi-Medi Plan (i.e. Medi-Cal MCP + EAE D-SNP)	**No (b/c CICM provided)**
Medi-Cal MCP + non-EAE D-SNP	**No (b/c CICM provided)**
Medi-Cal MCP + Regular MA Plan	**Yes**

[60] When a Member is enrolled in a D-SNP with a different parent organization than the Member's MCP, the MCP is still required to work with the D-SNP to help ensure effective care coordination across Medi-Cal benefits. To support these efforts, all D-SNPs and Medi-Cal MCPs in California are required to enter a care coordination point of contact in the D-SNP MCP Coordination Contact List (see the D-SNP Policy Guide for more information).

[61] Medicare Advantage Options for Dual Eligible Beneficiaries | DHCS

Medicaid & Medicare Delivery Model[61]	ECM Eligible
Medi-Cal MCP + Chronic Condition Special Needs Plan (C-SNP)	**Yes**
Medi-Cal MCP + Institutional Special Needs Plan (I-SNP)	**Yes**
Medi-Cal MCP + Original Medicare	**Yes**
Medi-Cal FFS + Original Medicare or Plan *(not MCP enrolled)*	**No**
Any other excluded program (e.g., 1915(c), CCT)	**No**

E. Other Programs

1. California Community Transitions (CCT) Money Follows the Person (MFTP)

MCP Members can be enrolled in ECM or in CCT MFTP, not in both at the same time.

- However, importantly, the "Adult Nursing Facility Residents Transitioning to the Community" Population of Focus is modeled off of the CCT Program;
- As such, MCPs are encouraged to contract with CCT Lead Organizations to leverage their expertise.

2. Hospice:

MCP Members receiving hospice are excluded from ECM.

3. California Wraparound

Child and youth MCP Members can be enrolled in ECM and California Wraparound. ECM enhances California Wraparound and coordinates across the case/care management available in California Wraparound. MCPs are expected to work with local California Wraparound County Coordinator[62] to ensure that Members receiving ECM services do not receive duplicative California Wraparound services.

[62] Microsoft Word - Wraparound County Coordinator List - 12.12.24

- California Wraparound (also known has High Fidelity Wraparound) is a strengths- based, needs-driven planning process and approach that occurs in a team setting to engage children and youth involved in child welfare, probation, and/or county SMHS with their families to live and grow up in a safe, stable, permanent family environment.[63]
- California Wraparound service components include: [64]
    - Integrated Core Practice Model (ICPM): Wraparound is aligned with ICPM, which includes principles and practices for serving children and youth in child welfare, behavioral health, and juvenile probation.
- The CFT process is core to ICPM. CFT includes the child or youth, their family, and professionals. When a child enters foster care, a child welfare social worker uses a variety of strategies to engage the child or youth and their families and other team members. The CFT develops and follows a service plan.
    - The Child and Family Plan is tailored to each child, youth, and family based on their specific needs and goals and should:
- Identify specific, incremental steps that move the child, youth, and family toward their specific goals and away from involvement with child welfare or probation agencies; and
- Define the roles and responsibilities of each team.
    - California Wraparound must also include, family support, peer advocacy and leadership, mentoring and coaching, community resource development, service evaluation, and cross–system collaboration.
    - Some Wraparound services can be billed to SMHS, including but not limited to Therapeutic Behavioral Services (TBS), Therapeutic Foster Care (TFC, sometimes called Treatment Foster Care), Intensive Home-Based Services (IHBS), ICC, case management, and rehabilitative services.

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[63] Refer to All County Information Notice No. I-52-15, All County Letter 21-116/BHIN 21-061 or superseding BHIN, and CDSS' California Wraparound webpage for more information on California Wraparound.

[64] The High Fidelity Wraparound Standards are currently being updated with CDSS, DHCS, the University of California, Davis, and stakeholders. See the draft version of the new California Wraparound Standards for more information. CDSS and DHCS intend to issue a joint letter when the new California Wraparound standards are finalized.

County child welfare, probation, and behavioral health agencies, in consultation with their county's Interagency Leadership Team, are required to provide California Wraparound for children and youth in foster care exiting from a short- term residential therapeutic program (STRTP) to a family-based, setting by October 1, 2023, per WIC 4096.6. But California Wraparound is otherwise a voluntary program for counties to opt- in.

4. Regional Centers Programs for Individuals with I/DD

Adult, child, and youth with an I/DD who are served by a Regional Center can be enrolled in ECM and a Regional Center.[65] *ECM enhances care for adults, children, and youth by improving care coordination and filling the gaps across the case/care management available from Regional Centers. MCP must ensure non-duplication of services between ECM and Regional Centers.*

- Regional Centers are community-based, non-profit agencies that operate statewide in California across 21 regions. Regional Centers are overseen by the California Department of Developmental Services (DDS) and provide assessments, determine eligibility for services, offer case management services, and develop, purchase, and coordinate services in each individual's Individual Program Plan.[66]
- To be eligible for Regional Center services, an individual must have an I/DD that begins before the individual's 18th birthday and that is expected to continue indefinitely and present a substantial disability. Regional Centers serve all ages of those who are eligible for services, from birth to end of life. [67]

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[65] I/DD for adults, children, and youth is defined in California by WIC 4512(a) as "a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature."

[66] Description and more information about Regional Centers is located on the Department of Developmental Services website.

[67] Regional Center eligibility information is located on the on the Department of Developmental Services website.

- Regional Centers may contract with MCPs to serve as ECM Providers, and they may refer Members they believe may be eligible for ECM.
- Individuals with I/DD who are not in a Regional Center are still eligible for ECM, so long as they meet the eligibility criteria for an existing Population of Focus (see Section IV. ECM Populations of Focus).
- Individuals with I/DD receiving 1915(c) waiver services and those residing in an ICF-DD are not eligible for ECM. If a Member will be transitioning out of an ICF/DD Home, the restriction of duplicative services is removed, and the Member must be assessed to determine need/eligibility for ECM services.
- Individuals with I/DD receiving 1915(c) waiver services and those residing in an ICF-DD are not eligible for ECM.

F. Programs Serving Pregnant & Postpartum Individuals

Adult and youth MCP Members participating in Comprehensive Perinatal Services Program (CPSP), Black Infant Health (BIH) Program, California Perinatal Equity Initiative (PEI), Indian Health Program, American Indian Maternal Support Services (AIMSS), CDPH's California Home Visiting Program (CHVP), CDSS' CalWORKs Home Visiting Program (HVP), and/or CDPH's Women, Infants & Children (WIC) program who meet the eligibility criteria of any ECM Population of Focus, including the Birth Equity Population of Focus, are eligible to receive ECM. MCPs are expected to work with the local administrators of each program to ensure Members do not receive duplicative ECM services. Providers serving these programs that meet the ECM Provider requirements detailed in Section VII. ECM Provider Network are encouraged to enroll as ECM Providers.

1. Comprehensive Perinatal Services Program (CPSP)

CPSP serves low-income pregnant and postpartum individuals statewide that are enrolled in Medi-Cal from the start of pregnancy to 60 days postpartum. CPSP provides obstetric services, health education, nutrition services, case coordination including strengths-based assessments, individualized care planning (reassessed each trimester), and postpartum assessment. CPSP is provided to FFS enrollees, with Medi-Cal MCPs required to provide comparable CPSP services to Members. CPSP is administered by CDPH.

2. Black Infant Health (BIH) Program

BIH Program serves Black pregnant and postpartum (up to 6 months) living in select California counties and cities, regardless of income, starting at age 16. BIH provides prenatal and postpartum group sessions, case management (for those who cannot attend group sessions), skills-based interventions (e.g., stress management, empowerment, healthy behaviors), and individual client-centered life planning. BIH is administered by county agencies, with funding and oversight provided by CDPH.

3. California Perinatal Equity Initiative (PEI)

California PEI serves pregnant and parenting Black individuals and their partners, up to the child's first birthday. PEI complements the BIH program for whole family care with home visitation programs, group interventions, and fatherhood and partnership initiatives. California PEI is administered by county agencies, with funding and oversight provided by CDPH.

4. Indian Health Program/American Indian Maternal Support Services (AIMSS)

The Indian Health Program aims to improve the health status of American Indians living in urban, rural, and reservation or rancheria communities throughout California. As part of the Indian Health Program, AIMSS provides perinatal case management and home visitation services to American Indian pregnant and postpartum individuals through the infant's first year of life. The program assists program participants with receiving health care, education, emotional support, referrals to services (social and health), and follow-up visits. AIMSS is administered by the Primary, Rural, and Indian Health Department (PRIHD).

5. CDPH California Home Visiting Program (CHVP)

CHVP serves pregnant and newly parenting families with at least one risk factor, including domestic violence, inadequate income, unstable housing, less than 12 years of education, SUD concerns, and/or mental health related issues. CHVP services are provided by a Public Health Nurse or paraprofessional in the family's house. This is a voluntary program with services beginning prenatally or right after labor and delivery until about age three, with the number of visits based on the family's need.

CHVP services include, but are not limited to, teaching parenting skills, providing information and guidance on newborns and infants, providing referrals to community resources, and screening children for developmental delays and facilitating interventions. As of December 2022, there are three evidence-based home visiting models approved by CHVP, with participating counties adopting different models to fit their communities: Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). CHVP is administered by CDPH with funding provided through the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program.

6. CDSS CalWORKs Home Visiting Program (HVP)

Home Visiting Program (HVP) is the California Work Opportunity and Responsibility to Kids (CalWORKs) voluntary home visiting program that serves individuals who are pregnant or parenting a child less than 24 months of age *and* are members of a CalWORKs assistance unit; parent or caretaker relative for a child-only case; pregnant individual who as applied for CalWORKS aid within 60 calendar days prior to reaching the second trimester of pregnancy and would be eligible for CalWORKs aid other than not having reached the second trimester of pregnancy; *or* an individual who is apparently eligible for CalWORKs second trimester of pregnancy; *or* an individual who is apparently eligible for CalWORKs aid. HVP services include, but are not limited to, prenatal, infant, and toddler care; infant and child nutrition; child developmental screening and assessments; parent education and child interaction; child development and care; job readiness and barrier removal; and treatment and supports for domestic violence and behavioral health concerns.

CDSS permits counties to operate HVP models that meet the U.S. HHS' evidence-based home visiting model requirements. HVP is supervised by CDSS and administered by participating California counties.

7. CDPH Women, Infant & Children (WIC) Program (Updated January 2026)

In California, 84 WIC local agencies at over 500 sites across the state support pregnant and postpartum individuals and their families in accessing healthy food, nutrition education, and lactation supports and services. To be eligible, applicants' annual household income must fall at or below 185 percent of the U.S. Poverty Income

Guidelines and deemed to have a nutritional risk.[68] WIC local agencies, which include local health departments and non-profit agencies, provide nutrition education and counseling as well as breastfeeding support, and provide referrals to health care and other community resources. In addition, the WIC local agencies issue the California WIC Card for families to purchase specific foods that provide key nutrients needed by pregnant and breastfeeding mothers, infants and young children.

VII. ECM PROVIDER NETWORK

A. Development of a Diverse ECM Provider Network (Updated January 2026)

ECM is designed to be delivered by community-based ECM Providers that enter into contracts with MCPs. [69]All exceptional scenarios in which the MCP will provide ECM in-house must be approved by DHCS in advance, as described below in the "MCP Serving as ECM Provider" section.

ECM Providers may include, but are not limited to, the following entities:

- Counties;
- County behavioral health Providers;
- PCPs or Specialist or Physician groups;
- FQHCs;
- Community Health Centers (CHCs);
- CBOs;

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[68] Medi-Cal and WIC have different federal poverty levels (FPL) for eligibility criteria. WIC's income eligibility criteria includes at or below 185% of the FPL (or, $28,952.50 annual income for a family size of one in 2025). Medi-Cal's income eligibility criteria for a pregnant person includes at or below 213% of the FPL (or $33,334.50 annual income for a family size of one in 2025) and up to 322% of the FPL (or $50,393.00 annual income for a family size of one in 2025) using the from-conception to-the-end-of-pregnancy CHIP-funded option. The annual U.S. federal poverty levels can be accessed on the Office of the Assistant Secretary for Planning and Evaluation (ASPE) website.

[69] To provide Members with ongoing care coordination provided in HHP and WPC Pilot counties before the launch of ECM in 2022, MCPs were expected to contract with each WPC Lead Entity or HHP Community-Based Care Management Entity (CB- CME) as an ECM Provider unless there was an applicable exception.

- Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
- Rural Health Clinics (RHCs);
- Indian Health Service Programs;
- Intimate partner violence and domestic violence shelters and organizations (including those serving pregnant and postpartum individuals and families);
- Local health departments;
- Behavioral health entities;
- Community mental health centers;
- SUD treatment Providers;
- CBAS Providers;
- SNFs;
- Organizations serving individuals experiencing homelessness;
- Organizations serving justice-involved individuals;
- Organizations serving pregnant and postpartum individuals (including organizations and entities with perinatal expertise in home visiting, intimate partner violence, behavioral health, nutrition services (including local WIC agencies), and housing;
- CCS Providers;
- Regional Centers;
- County First 5s;
- School-Based Health Centers; and
- Other qualified Providers or entities that are not listed above, as approved by DHCS.

In order to ensure that the needs of all ECM Populations of Focus are met, **MCPs must contract with ECM Providers specializing in each of the specific Populations of Focus, who have an existing footprint in the communities they serve.** MCPs are discouraged from relying on a single type of provider.

DHCS also expects MCPs to work in close collaboration, and prioritize contracting with, counties – including county behavioral health systems (who often are the

primary Providers of services to a subset of Medi-Cal beneficiaries), and counties in their role as payers and providers of services to children.

ECM Providers do not have to have prior experience serving Medi-Cal MCP Members specifically. MCPs should determine what they deem as "sufficient experience" and should think creatively about how to engage Providers with POF-specific expertise.

DHCS is monitoring MCPs' ECM and Community Supports networks for the inclusion of counties, as well as the inclusion of diverse provider types generally.

DHCS strongly encourages MCPs to form contracts with the following provider types:

Adult ECM Populations of Focus	Example Priority Provider Types
Adults with Serious Mental Health and/or SUD Needs	» County Departments of Behavioral Health » Community-Based Behavioral Health and Medication-Assisted Treatment (MAT) providers who also provide SMHS and/or » DMC/DMC-ODS services » Perinatal Providers with an Expertise in Behavioral Health (e.g., Psychiatrists, Psychologists, Licensed Marriage and Family Therapists)
Individuals and Families Experiencing Homelessness	» Street Medicine providers » Homeless Navigation Centers » Transitional Housing for Homeless Youth » Homeless Shelters and Domestic Violence Shelters for Pregnant and Postpartum Individuals and Families
Adult Birth Equity Population	» Maternity Providers (e.g., OB/GYNs, Family Medicine Physicians, Midwives, CPSP providers) » Organizations with Care Teams that include Doulas, Community Health Workers (CHWs), and Promotoras

Adult ECM Populations of Focus	Example Priority Provider Types
	» Home Visiting Providers » Dyadic Services Providers » Organizations that Provide Perinatal Behavioral Health Services with Care Teams that include Psychiatrists, Psychologists, and Licensed Marriage and Family Therapists » Local WIC Agencies
Adult Nursing Facility Residents Transitioning to the Community	» California Community Transitions Lead Organizations » Affordable Housing Communities » Memory Care, Assisted Living, and Independent Living Organizations » Alzheimer's Association
Adults Living in the Community and At Risk for LTC Institutionalization	» CBAS Centers » Area Agencies on Aging » Home Health Agencies » Centers for Independent Living » Alzheimer's Association » Memory Care, Assisted Living, and Independent Living Organizations

Children/Youth ECM Populations of Focus	Example Priority Provider Types
Children with Serious Mental Health and/or SUD Needs (includes children with high ACEs scores)	» School-based clinics/BH providers » Public Health & Social Service Programs » CBOs serving children and families with social needs

Children/Youth ECM Populations of Focus	Example Priority Provider Types
	» County Behavioral Health Services
Children and Youth Enrolled in California Children's Services (CCS)	» CCS paneled providers, including specialty care centers, and pediatric acute care hospitals » CCS Classic Case Management providers
Children and Youth At Risk for Avoidable Hospitalization or ED Use	» School-based clinics » Medical providers depending on underlying reasons for ED utilization
Children and Youth Involved in Child Welfare	» CBOs, Public Health & Social Service Programs: First 5, Help Me Grow, WIC, Black Infant Health Program, County Foster Care agencies, etc.
Children and Youth Birth Equity Population	» Maternity Providers (e.g., OB/GYNs, Family Medicine Physicians, Midwives, CPSP providers) » Organizations with Care Teams that include Doulas, Community Health Workers (CHWs), and Promotoras » Home Visiting Providers » Dyadic Services Providers » Organizations that Provide Perinatal Behavioral Health Services with Care Teams that include Psychiatrists, Psychologists, and Licensed Marriage and Family Therapists » Local WIC Agencies

B. ECM Provider Directory

1. MCPs are to list all ECM and Community Support Providers in the Provider Directory as Other Services Providers.
    a. MCPs should specify if a Provider is an ECM, Community Supports Provider, or both.
    b. MCPs' network directories should indicate which Population(s) of Focus each ECM Provider is equipped to serve.
    c. DHCS recognizes some MCPs already have a section for Other Services Providers, while some MCPs may have to **create a new** "Other Services Providers" section.
2. MCPs will need to add a disclaimer in the Directory stating that both ECM and Community Supports require prior authorization and are limited to Members who meet specific eligibility criteria.
3. MCPs may use symbols denoting ECM or Community Supports Providers that may be listed in other sections of the Directory in lieu of listing Providers multiple times.

1. Formal Agreements with Other Entities

ECM Providers should also 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. MCPs have the discretion to determine which agreements are necessary or acceptable to meet this requirement, acknowledging that provider organizations will vary greatly in their capacity to share data outside their four walls.

C. Requirements to Be an ECM Provider

1. Culturally Appropriate and Timely Care

ECM Providers must have the capacity to provide culturally appropriate and timely in-person care management activities. ECM Providers and Lead Care Managers must meet Members where they are in terms of the physical location that is most convenient and desirable for the Member to engage in services and from a medical management and plan of care perspective. ECM Providers must be able to communicate with Members in a culturally and linguistically appropriate and

accessible way and be able to respectfully engage with Members who have been historically marginalized and/or are experiencing health disparities.

2. Screening, Enrollment, Credentialing, Revalidation, and Recredentialing Requirements (Updated September 2026)

During the provider screening, enrollment, credentialing, revalidation and recredentialing process and on a regular basis, MCPs are required to determine the exclusion and/or enrollment status. MCPs must do so in accordance with APL 22-013 (or superseding APL) and APL 21-003 or superseding APL, by verifying federal and State exclusion lists, no less than monthly.

Payments made by the MCP to an ECM provider – including for those that are not considered a Network Provider (i.e., the MCP has a letter of agreement or single case agreement) must only be made to those providers who have gone through the screening, enrollment, and revalidation process in accordance with APL 22-013 (or superseding APL).

i. Screening and Enrollment

Under federal Medicaid regulations, all enrolling and currently enrolled Medi-Cal providers must comply with federal disclosure, screening, monitoring, reporting and enrollment requirements outlined in 42 CFR Part 455. These requirements apply uniformly to all provider types, including those enrolled by DHCS, via another state-level enrollment pathway, or by the MCP.

MCPs are responsible for the screening, enrollment, revalidation, and credentialing, and recredentialing for all ECM providers in order to contract with the ECM provider as a Network Provider in accordance with in 42 CFR Part 455, the ECM Policy Guide, the MCP contract and APL 22-013 or superseding APL.

MCP Network Providers (including those that will operate as ECM or Community Supports Providers) are required to enroll as a Medi-Cal Provider only if there is a state- level enrollment pathway for them to do so.[70] For example, clinics, physician groups, nurse practitioner groups, etc, will enroll as a clinic, physician/nurse group, but will not separately enroll as ECM or CS. For-profit organizations delivering ECM and CS exclusively generally do not have an enrollment pathway. For those ECM and

[70] ECM Providers who serve the Justice-Involved POF are required to become a Medi-Cal enrolled provider. For details, see the CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance

Community Supports Providers with a state-level Medi-Cal enrollment pathway, the process for enrolling is identical to any other provider. The Provider must enroll through the DHCS Provider Enrollment Division, or other state recognized pathway.

ii. Credentialing

As per the MCP contract, credentialing means the process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure, and professional association membership. APL 22-013 or superseding APL gives details on MCP credentialing requirements. MCPs must take any actions, as needed, in addition to the steps listed above under screening and enrollment to credential all ECM Providers, as appropriate to meet the requirements of APL 22-013 or superseding APL. MCPs may align screening and enrollment efforts with their credentialing efforts to reduce duplication of activities.

iii. Revalidation of Enrollment

To ensure that all enrollment information is accurate and up-to-date, MCPs must ensure all providers -resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. As per APL 22-013 or superseding APL, MCPs must revalidate the enrollment of each of their Network Providers at least every 5 years. MCPs may align revalidation efforts with their re-credentialing efforts to reduce duplication of activities. MCPs are not required to revalidate providers that were enrolled through DHCS (i.e., the state-level enrollment pathway) or another MCP within the required timeframes. However, MCPs are required to ensure that the credentialing files demonstrate timeframes of screening, enrollment, revalidation, and recredentialing activities and indicate files are up to date.

iv. Recredentialing

As per APL 22-013 or superseding APL, DHCS requires each MCP to verify every three years that each Network Provider continues to possess valid credentials, as applicable. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of APL 22-013 or superseding APL, in the same manner, as applicable. Re-credentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, Member grievances, and medical record reviews. The re-credentialing application must include the same attestation as contained in the provider's initial application.

v. Clarifying Relationship with Provider "Credentialing" Requirements of APL 22-013 or superseding APL

Many ECM and Community Supports Providers (e.g., housing agencies, medically tailored meal Providers) may not have a state-level enrollment pathway. These providers must enroll in the Medi-Cal program via a pathway that is approved by DHCS that meets all of the requirements in accordance with in 42 CFR Part 455, the ECM Policy Guide, the MCP contract and APL 22-013 or superseding APL.

DHCS does not set licensing requirements for ECM care managers. MCPs should use and build on the processes they have already established for reviewing the qualifications and experience of ECM Providers.

To include an ECM and Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to enroll the Provider or Provider organization, credential them and ensure they meet the standards and capabilities required to be an ECM or Community Supports Provider. MCPs must submit Policies and Procedures for how they will enroll, credential and ensure the qualifications of ECM and Community Supports Providers in their submission of Part 2 of the MOC. MCPs must create and implement their own processes to do this.

Criteria MCPs may want to consider as part of their process to ensure that the ECM provider is qualified to serve as an ECM provider include, but are not limited to:

- Ability to receive referrals from MCPs for ECM or the authorized Community Supports;
- Sufficient experience to provide services similar to ECM for Populations of Focus and/or the specific Community Supports for which they are contracted to provide;
- Ability to submit claims or invoices for ECM or Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste and/or abuse;
- Recent history of criminal activity that endangers Members and/or their

families; [71] and

- History of liability claims against the Provider.

MCPs should also consider national accreditation and /or certification standards.

3. Program Integrity:

MCPs are required to ensure that ECM services are delivered in a manner that adheres to program integrity requirements. An MCP may immediately terminate its agreement with a Network Provider when the MCP conducts an internal investigation and determines there is credible evidence that the individual or entity has committed Fraud, Waste, or Abuse (FWA).[72]

- MCPs must notify DHCS Program Integrity Unit of all identified FWA as directed. Although MCPs may immediately terminate an individual or entity for this reason prior to notifying DHCS, MCPs must still ensure they have a sufficient provider network to deliver ECM services and ensure impacted Members are transferred to alternate Network Providers as appropriate to avoid delays in care. If MCPs cannot ensure access using Network Providers, they must authorize out-of-Network care for Members as appropriate.
- MCPs should also apply pre-payment and other analytics to support program-integrity monitoring and prevent potentially fraudulent or abusive activities. MCPs and ECM Providers should routinely flag and report anomalies or patterns to support effective oversight.

4. MCP Delivering ECM Services Directly Rather than Contracting to Network Providers

If an MCP is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus in a community-based manner through contracts with ECM Providers, they may request written approval for a time-bound exception to use their

[71] Note that ECM Providers serving the Individuals Transitioning from Incarceration Population of Focus may have lived experience with the justice system.

[72] The definitions for "fraud," "waste," and "abuse" are separately defined in the MCP Contract, Exhibit A, Attachment I, Article 1.0 (Definitions). See also MCP Contract, Exhibit A, Attachment III, Subsection 1.3.2.D (Fraud Prevention Program); and See APL 21-003 "Medi-Cal Network Provider And Subcontractor Terminations" or superseding APL.

own staff to deliver ECM services. [73] [74]In these limited circumstances, MCP staff must also comply with all the requirements of being an ECM Provider (e.g., providing ECM services through in-person interactions and in the community). Any such request must be submitted in accordance with DHCS guidelines and must evidence one or more of the following:

- There are insufficient ECM Providers, or a lack of ECM Providers with experience and expertise to provide ECM for one or more of the Populations of Focus in one or more counties;
- There is a justified quality-of-care concern with one or more of the otherwise qualified ECM Providers;
- Contractor and the ECM Provider(s) are unable to agree on contracted rates;
- Potential ECM Provider(s) is/are unwilling to contract;
- Potential ECM Provider(s) is/are unresponsive to multiple attempts to contract;

  (For ECM Providers that have a state-level pathway to Medi-Cal enrollment) Provider(s) is/are unable to comply with the Medi-Cal enrollment process; or
- (For ECM Providers without a state-level pathway to Medi-Cal enrollment) Provider(s) is/are unable to comply with Contractor's processes for vetting ECM Providers.

During any exception period approved by DHCS, the MCP must take steps to continually develop and increase the capacity of its ECM Provider Network. The initial exception period will be in effect no longer than one year. After the initial one- year period, the MCP must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis. Ultimately, these procedures have been established to align with the vision of providing ECM services through an in-person, community-based approach.

D. Requirement to have a Care Management Documentation System (Updated January 2026)

[73] For additional detail on ECM Provider network exceptions, see Expectations for ECM Provider Networks & Approved Exceptions (Updated January 1, 2023).

[74] DHCS expects those MCPs who transitioned from HHP in 2022 to have made efforts to shift previous models to a more community-based Provider approach. DHCS will continue monitoring MCPs timely progress.

ECM Providers must 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 a Member care plan that can be shared with other Providers and organizations involved in each 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 or long-term care facility, housing status).

MCPs may not require ECM Providers to utilize an MCP portal for documentation of ECM services—MCPs must be able to accept data on documentation of ECM services when it is submitted in a standardized, machine-readable format. However, MCPs may choose to offer access to their care management documentation system as an option for Providers. DHCS understands that requirements to use MCP portals can create duplicative documentation and be administratively burdensome to Providers. MCPs may continue to use their portals to exchange Member information lists and authorization information, but should not otherwise require Providers to use the portal.

E. ECM Provider Payment

MCPs must pay contracted ECM Providers for the provision of ECM in accordance with contracts established between MCPs and each ECM Provider. MCPs must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member. MCPs are expected to reimburse ECM Providers for outreach, including for unsuccessful outreach that did not result in a Member enrolling into ECM. MCPs are encouraged to tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status. In June 2023, DHCS launched a Supplemental Data Request (SDR) process to better understand the rates being paid by MCPs to ECM Providers and will use this data to inform future efforts to standardize thresholds which trigger payment.

DHCS' vision is that ECM Providers will submit encounters to MCPs for transmission to

DHCS. Providers that do not have these capabilities must be allowed to submit invoices to MCPs. DHCS has developed more comprehensive guidance that describes the minimum set of data elements required to be included in an invoice, available from the ECM Resource Directory.

ECM is subject to the standard reimbursement timelines as other Medi-Cal services. As specified in:

- The Medi-Cal Managed Care Boilerplate Contract: MCPs must pay 90% of all clean claims within 30 days of the date of receipt and 99% of all clean claims within 90 days.
- California Health and Safety Code Section 1371: MCPs must reimburse claims or any portion of any claim, as soon as practicable, but no later than 30 working days after receipt of the claim and are subject to interest payments if failing to meet the standards.
- APL 23-020 or superseding APL : MCPs must pay all claims within contractually mandated statutory timeframes and maintain sufficient claims processing/tracking/payment system capabilities. DHCS expects MCPs to pay clean claims within 30 days of receipt.

These requirements pertain to both invoices and claims submitted by ECM. MCPs are required to train their contracted network of ECM Providers on how to submit a clean claim and must have personnel available to troubleshoot issues with ECM Providers.

VIII. ENGAGING MEMBERS IN ECM

A. Members for ECM

MCPs are responsible for driving ECM enrollment through community-based referrals and by regularly and proactively identifying Members who may benefit from ECM and who meet the criteria for the Populations of Focus. To do this effectively, MCPs must consider Members' health care utilization; needs across physical, behavioral, developmental and oral health; health risks and needs due to SDOH; and LTSS needs.

B. ECM Referrals for Members (Updated January 2026)

DHCS is committed to standardizing key areas of ECM program design to reduce administrative burden, promote better community awareness of ECM, and improve

ECM access and uptake across the state. DHCS conducted extensive stakeholder feedback on early implementation of ECM across the state in 2023 which resulted in an ECM/Community Supports "Action Plan" and a published ECM/Community Supports "Cheat Sheet" summarizing the areas for standardization and reforms to streamline access to both services. Reforms to standardize ECM referrals and authorization are a key component of the ECM/Community Supports Action Plan.

Universal ECM Referral Standards: DHCS has created ECM Referral Standards to standardize and streamline ECM referrals made to MCPs from ECM Providers, healthcare providers, community partners, and other entities. **Effective January 1, 2025, all MCPs are required to operationalize guidance in the ECM Referral Standards,[75] including updating existing ECM referral forms to align with the guidance.** DHCS created ECM Referral Standards to improve the consistency of information collected by MCPs to process an ECM referral, so that entities making referrals to multiple MCPs have a predictable, common set of information they must send on each Member referred to ECM. This also is intended to support DHCS' vision that the majority of ECM referrals originate from community-based sources (e.g. primary care providers, case managers, hospitals, social service providers, Medi-Cal Members, etc.), as these entities often have an existing relationship with the Member, and community-based referrals have demonstrated higher rates of ECM engagement/acceptance. These ECM Referral Standards build on – and supersede – previous ECM Member Information Sharing Guidance for ECM referrals ("Potential ECM Member Referral File"), which will be eliminated.

1. No Additional Documentation for ECM Referrals and Authorization:

MCPs may **not** require nor request community partners or ECM Providers to submit supplemental eligibility checklists, outreach authorization forms, ICD-10 codes, additional proof of homelessness, Treatment Authorization Request (TAR) forms, or other supplemental information beyond the information provided in the ECM Referral Standards to confirm eligibility and authorize ECM. Through stakeholder feedback, DHCS determined there was previously significant variation in the supplemental documentation MCPs requested from community referral partners and ECM Providers to verify a Member's eligibility for ECM. Information outlined in the DHCS ECM Referral Standards are the only elements MCPs can require to determine Member eligibility and authorize ECM. MCPs may collect additional Member information for the purposes of supporting Member outreach and care coordination as long as this is

[75] For more information, see the ECM Referral Standards and Form Templates.

distinct from the eligibility and authorization determination and does not disrupt the timing of the eligibility and authorization determination.

The ECM Referral Standards are designed to align with Closed-Loop Referral (CLR) for MCPs. DHCS CLR Implementation Guidance details MCP requirements for tracking, supporting and monitoring referrals to ECM and Community Supports. CLR implementation guidance is detailed in an addendum to the PHM Policy Guide, updated in May 2025.

The primary mechanism for Member identification for ECM should be referrals from the community. MCPs must inform Members and their families, guardians and caregivers, ECM Providers, Community Supports Providers, other Providers, and CBOs about ECM, the ECM Populations of Focus, and the process to request ECM. MCPs must consider requests for ECM on behalf of Members from all of the entities described above. DHCS expects MCPs to source the majority of referrals for ECM from the community i.e., from the MCP's network of providers (inclusive of PCPs and other clinical Providers, ECM and Community Supports Providers) and other community-based referral sources, including the entities described above. **Thus, each MCP is expected to maintain and grow a strong process to receive and respond to referral requests, regardless of whether they originate from ECM Providers or from other entities**. For example, shelters, homeless services providers, recuperative care providers and other service providers will be better positioned to identify individuals and families experiencing homelessness. Similarly, county behavioral health plans will be well-positioned to refer adults with serious mental health and/or SUD needs who may benefit from ECM.

MCPs should actively monitor sources of referrals for ECM, levels of Member engagement/acceptance of ECM, and improving overall referral and engagement patterns to improve ECM utilization among eligible Members. As part of this monitoring, MCPs should track referral source mix in pursuit of having a majority of ECM referrals originate from community-based sources, rather than from the MCP itself. In addition, MCPs should actively assess which Members may have pre-existing relationships with certain ECM Providers and ensure that qualifying Members are being assigned to those ECM Providers with whom they have a relationship, independent of what the source of the referral is to ECM.

MCPs must have clear instructions for making referrals to ECM on their public-facing webpage(s). The MCP Evidence of Coverage Member Handbook and public-facing webpage(s) must include up to date Member and provider-facing information about

ECM, how to make a referral to ECM using the ECM Referral Standards, and how to request an assessment for ECM. MCPs must also ensure that call center staff receive training on ECM and are prepared to either complete an ECM referral or efficiently route callers to MCP staff who can support a caller in completing a referral to ECM.

MCPs are encouraged to work with other MCPs, PATH Collaborative Planning and Implementation (CPI) Facilitators and ECM Providers to improve community knowledge and awareness of ECM and educate key referral sources on pathways to making referrals to ECM using the ECM Referral Standards.

C. MCP Identification of Members

In addition to referrals, there are a number of potential data sources MCPs can leverage to identify Members for ECM, including but not limited to:

- Enrollment data;
- Encounter data;
- Utilization/claims data;
- Pharmacy data;
- Laboratory results data;
- Assessment data;
- Clinical information on physical and/or behavioral health;
- ADT feed data;
- Local Health Information Exchange data;
- Health Information Form (HIF)/Member Evaluation Tool (MET) data;
- Utilization data from PCPs, including but not limited to results of the Individual Health Appointment, services, and screenings recommendation by the U.S. Preventive Services Task Force and American Academy of Pediatrics/Bright Futures;
- Health Risk Stratification and Assessment survey for Seniors and Persons with Disabilities (SPD);
- Behavioral Health/SUD data, as available;
- Regional Center data;

- Child Welfare data (including foster care, Adoption Assistance Program, and Family Maintenance);
- First 5 program data;
- School-based health centers data and school absences data, as available;
- School district McKinney-Vento Program eligibility screenings to identify students experiencing homelessness;
- Risk stratification information for children in County Organized Health System (COHS) counties with CCS WCM programs;
- Information about SDOH, including standardized assessment tools and/or ICD-10 (International Classification of Diseases) codes;
- Results from any available ACEs screening; and
- Other cross-sector data and information, including housing, social services, criminal justice history and other information relevant to the ECM Populations of Focus (e.g., HMIS, available data from the education system).

Using data listed above, risk stratification and segmentation models performed by the plan will also be used to identify ECM Members. MCPs will need to rely on a combination of information provided by DHCS on a regular basis and data internal to the plan. DHCS provides encounter data, including physical and behavioral health utilization, to MCPs monthly in a standard file format. For example, to identify Members with a pattern of avoidable hospital or ED utilization, MCPs could rely on the frequency of utilization reflected in the data feeds from DHCS. Whenever feasible, MCPs should also consider any data or relevant characteristics provided as part of data exchanged between the MCP and Provider organizations.

D. Authorizing ECM for MCP Members (Updated January 2026)

Through the ECM and Community Supports Action Plan, DHCS established priorities that streamline and standardize access to ECM and Community Supports for Members across Managed Care Plans, and outlined the areas of standardization in both services for MCPs, providers and community partners in the ECM/Community Supports Cheat Sheet. The Action Plan identified improving ECM authorization processes as a high priority in order to streamline authorization processes for select Providers and enable services to be rendered immediately to ECM-eligible Members. In 2023, DHCS standardized authorization timeframes for ECM and emphasized the application of

agency guidance for processing authorizations in accordance with APL 21-011 or superseding APL.

MCPs must implement streamlined authorization (formerly referred to as "presumptive authorization") arrangements with select ECM Providers. In 2026, DHCS renamed "presumptive authorization" to "streamlined authorization" to clarify that the policy does not change existing requirements and authorities for MCPs to do full reviews of Members' ECM eligibility and make authorization decisions and does not shift the authorization function to ECM Providers. However, the underlying streamlined authorization policy requirements did not change. The ECM streamlined authorization policy enables a subset of ECM Providers to initiate ECM services for a timeframe of 30 calendar days, so they can more rapidly engage Members in the care they need, as described below. DHCS is releasing updates to the ECM streamlined authorization policy in parallel to the ECM Referral Standards that together are designed to ease the administrative burden of the referral and authorization process on ECM Providers and community referral partners. The ECM streamlined authorization policy does not change existing requirements on ECM authorization timeframes and authorization processing requirements in APL-21-011 or superseding APL (within five working days for routine authorizations and within 72 hours for expedited requests). ECM streamlined authorization is distinct from "presumptive eligibility" policies for Medi-Cal coverage for special populations (children, pregnant individuals, individuals experiencing homelessness) that enable some health care providers to apply for immediate, temporary health coverage under Medi-Cal for individuals. [76]In practice, both policies can work together to serve some of Medi-Cal's most vulnerable populations.

Standard ECM Authorization Timeframes (Updated January 2026)*:* For all Members authorized to receive ECM by their MCP, the initial authorization period will be 12 months and the reauthorization period will be 6 months. MCPs may not impose additional requirements for authorization of ECM services beyond the Population of Focus eligibility criteria specified by DHCS. For example, MCPs may not withhold an authorization until a care plan has been completed.

MCPs must follow the guidance below that was issued previously for all ECM authorization requests. The DHCS ECM Referral Standards and ECM streamlined

[76] For more see DHCS policy: Hospital Presumptive Eligibility Program (ca.gov), Children's Presumptive-Eligibility (ca.gov), Presumptive Eligibility (ca.gov).

authorization policy do not change existing DHCS requirements outlined below. For requests from Providers, other external entities, Members or family:

- **DHCS emphasizes that the MCP must ensure that authorization or a decision not to authorize ECM occurs as soon as possible (i.e., within five working days for routine authorizations and within 72 hours for expedited requests), in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 21-011 or superseding APL.**
- Requirements for timely processing of authorization requests applies in **all** cases including requests for streamlined authorization; requests that are submitted individually or by batch, machine-readable file formats or alternative submission processes; requests submitted by Members and their families; ECM Providers, a Community Partner, and other referring entities.
- If the MCP does not authorize ECM, the MCP must ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf are informed of the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System, and APL 21-011 or superseding APL.
- For Members who were not authorized to receive ECM, the MCP must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011 or superseding APL.
- To inform Members that ECM has been authorized, the MCP must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and APL 21-011 or superseding APL.

E. ECM Streamlined Authorization Requirements (Updated January 2026)

The goal of ECM streamlined authorization arrangements is to allow select ECM Providers who are already contracted in the MCP's ECM Provider network to more rapidly initiate ECM services for Members and to increase certainty of MCP payment

during a 30-day streamlined authorization timeframe. The select ECM Providers eligible for streamlined authorization often care for Members eligible for the ECM POFs the Providers serve, such as OB/GYN Practices contracted to provide ECM to the Birth Equity POF. **ECM streamlined authorization applies only to entities that are already contracted ECM Providers with the MCP and does not extend to other entities referring Members to MCPs for ECM.**

DHCS defines ECM streamlined authorization as an arrangement between an MCP and an ECM Provider in their network that enables that ECM Provider to initiate ECM services for a Member during a 30 calendar day timeframe and be paid by the Member's MCP for ECM services delivered during the 30 days. During the streamlined authorization period, the ECM Provider must submit the Member's referral information to the MCP for formal authorization to continue to receive reimbursement for services beyond the streamlined authorization timeframe. MCPs should encourage ECM Providers to submit their referral for ECM to MCPs as soon as possible and no later than five working days before the end of the streamlined authorization period to limit gaps in authorization and reimbursement for ECM services provided to Members.

ECM Provider Types for ECM Streamlined Authorization Requirements: MCPs must implement streamlined authorization for ECM for a subset of ECM Provider types – each paired with a specific ECM Member POF (Figure 5).

MCPs are required to implement streamlined authorization arrangements with the specific ECM Providers in their networks serving the specific Populations of Focus listed in Figure 5. To fall under ECM streamlined authorization requirements, ECM Providers must be contracted in network with the Member's assigned MCP to provide ECM for the POF in Column 1 **and** meet the provider type requirements outlined in Column 2.

Figure 5: ECM Provider Eligibility for Streamlined Authorization [77]

Column 1: ECM Population of Focus	Column 2: ECM Providers Covered by Streamlined Authorization Requirements
1) Adults & Children Experiencing Homelessness	» Street Medicine providers » Community Supports Providers of the Housing Trio Services: Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services » County-contracted and County-operated Specialty Behavioral Health Providers
2) Adults & Children At Risk of Avoidable Hospital or ED Utilization	» Primary Care Provider practices (including Federally Qualified Health Centers (FQHCs)), County-operated primary care, and other primary care
3) Adults & Children with Serious Mental health and/or SUD Needs	» County-contracted and County-operated Specialty Behavioral Health Providers
4) Adults & Children Transitioning from Incarceration	» Existing DHCS guidance governs authorizations and warm handoffs to support Members receiving prerelease services in the JI POF. Refer to CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance for details.[78]

[77] For Providers contracted to deliver both ECM and Community Supports, eligibility for ECM presumptive authorization does not impact Community Supports authorization processes [74] A Member who receives pre-release services must be presumptively/retroactively authorized to receive ECM services on the day of release or, if MCP enrollment is effectuated after release, on the day of MCP enrollment.

[78] A Member who receives pre-release services must be presumptively/retroactively authorized to receive ECM services on the day of release or, if MCP enrollment is effectuated after release, on the day of MCP enrollment.

Column 1: ECM Population of Focus	Column 2: ECM Providers Covered by Streamlined Authorization Requirements
5) Adults Living in the Community and At Risk for LTC Institutionalization	» California Community Transitions (CCT) lead Organizations » Community Supports Providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services
6) Adult SNF Residents Transitioning to the Community	» California Community Transitions (CCT) lead Organizations » Community Supports Providers of the Nursing Facility Transition/Diversion to Assisted Living Facilities and Community Transition Services
7) Children & Youth Enrolled in CCS/CCS WCM	» CCS Paneled Providers and Local Health Department CCS Programs
8) Children & Youth involved in Child Welfare	» County-contracted and County-operated Specialty Behavioral Health Providers » High Fidelity Wraparound Providers » Health Care Program for Children in Foster Care » Department of Social Services (DSS) Offices » Foster Family Agencies » Transitional Housing Programs Current and Former Foster Youth » Children's Crisis Residential Programs
9) Birth Equity Population of Focus	» OB/GYN Practices » Midwifery Practices » Entities that deliver the following services: Black Infant Health (BIH) Program, Perinatal Equity Initiative (PEI), Indian Health

Column 1: ECM Population of Focus	Column 2: ECM Providers Covered by Streamlined Authorization Requirements
	Program, American Indian Maternal Support Services (AIMSS)

MCPs are only required to implement ECM streamlined authorization for an ECM Provider contracted to provide ECM for the specific POFs outlined in the Figure 5.

1. Example 1: Local Health Department CCS Program Provider eligibility for streamlined authorization:

- A child is enrolled in CCS and their county-based CCS case manager determines that the child and family need additional care management offered through ECM.
- If the county health department providing CCS is also an ECM Provider contracted with the child's MCP for the Children & Youth Enrolled in CCS POF, then the team can initiate services for the Member and be reimbursed for services under a streamlined authorization arrangement for up to 30 days while they complete the ECM referral for the child and await the MCP's ECM authorization decision.
- Alternatively, if the county is not contracted as an ECM Provider with the MCP for the Children & Youth Enrolled in CCS POF, it would not be able to access ECM streamlined authorization arrangements for this POF and would refer the child to the MCP for ECM. The MCP would assign the child to an ECM Provider from its network that would be most appropriate to meet the child's needs (e.g. the PCP practice, if in network).

2. Example 2: Street Medicine Provider eligibility for streamlined authorization:

- An entity operating as both a Street Medicine Provider and as an ECM Provider contracted in the MCP's network for the Individuals and Families Experiencing Homelessness POF can presumptively authorize Members eligible for this specific POF.

The DHCS-required pairings of ECM Providers and POFs for streamlined authorization are minimum requirements and do not limit MCPs from extending streamlined authorization arrangements to more ECM Providers or additional

POFs. The MCP and ECM Provider can discuss options for expanding ECM streamlined authorization authority beyond the DHCS minimum requirements.

- In Example 2, if the Street Medicine Provider/ECM Provider identifies a Member who meets eligibility only through a different POF (e.g. Birth Equity POF), DHCS policy does not require the MCP to presumptively authorize this Member. However, the MCP could still decide to extend streamlined authorization to this POF through agreements with the ECM Provider.

Streamlined authorization requirements apply only to the initial ECM authorization for the Member, not subsequent renewals and re-authorizations.

MCP Payment and Streamlined Authorization: MCPs must allow network ECM Providers under streamlined authorization to start billing for ECM services from the date the Member first receives ECM services. **In a case where the MCP subsequently denies the ECM authorization, the MCP must reimburse the ECM Provider throughout the streamlined authorization timeframe up until the end of the day that the MCP makes an authorization determination and communicates the denial to the ECM Provider**. As a result, the streamlined authorization timeframe is 30 days or up to the date the MCP makes and communicates the authorization decision to the ECM Provider, whichever comes sooner. MCPs should encourage ECM Providers to submit ECM referrals to MCPs as soon as possible and no later than five working days before the end of the 30 days to ensure MCPs have sufficient time to authorize ECM before the end of the streamlined authorization timeframe.

Services rendered during the 30-day streamlined timeframe remain reimbursable even if the MCP does not ultimately authorize the Member for ECM. The two exceptions to the requirement for payment are:

1. MCPs are not responsible for reimbursing for ECM services for individuals who are not Members of their Managed Care Plan during the time of ECM service delivery
2. MCPs are not responsible for reimbursing for ECM services in cases when the MCP determines that a Member has an existing, open ECM authorization with another ECM Provider. DHCS allows for this exception in MCP payment to limit instances of payment for duplicative services.

To reduce the risk that ECM Providers are not reimbursed for services due to an existing ECM authorization, MCPs must make Members' ECM authorization statuses accessible to ECM Providers via their Plan Portal or similar online system

by January 1, 2025 to support ECM Providers in accessing a Member's existing ECM authorization information. As a best practice, an MCP may also provide a direct telephone line to a knowledgeable staff member at the Plan who can look up and verify a Member's ECM authorization status for ECM Providers. As another best practice, MCPs can also make ECM enrollment and assigned lead ECM care management information available via Qualified Health Information Organizations (QHIOs).

MCPs must train ECM Providers under streamlined authorization arrangements on how to review each Member's existing authorization status for ECM to confirm the Member is not already authorized for ECM with another Provider. Additionally, MCPs must train ECM Providers on best practices in asking Members about their enrollment in key programs that overlap with ECM and may result in a later authorization denial by the MCP (e.g. 1915(c) waivers, D-SNP enrollment).

In cases where the ECM Provider determines that the Member they would like to serve under streamlined authorization has an existing ECM authorization, the ECM Provider should consult with the Member and follow DHCS guidance on Member preference for ECM Provider assignment to work with the MCP and determine whether the ECM Provider for the Member should be changed (*Section VIII of the ECM Policy Guide)*.

Outreach and Streamlined Authorization: MCPs may not require ECM Providers under the ECM streamlined authorization policy to seek MCP authorization to conduct and bill for outreach efforts to identify new Members for ECM.

F. Utilization Management Authority for ECM: (Added September 2026)

MCPs retain full utilization management (UM) authority for all ECM services, consistent with federal managed care regulations, the Medi-Cal MCP Contract, and DHCS policy guidance, including streamlined authorization requirements, to ensure clinically appropriate utilization of ECM. MCPs are responsible for establishing and applying UM criteria, including on authorization timelines, service duration standards, and reassessment schedules, to ensure ECM services are delivered in an economic, efficient, medically appropriate, and outcomes-oriented manner that ensures program integrity. MCPs may apply UM protocols and make determinations regarding authorization, reassessment, service duration, and termination for sustained lack of engagement or when a service is

no longer appropriate, so long as these processes align with DHCS guardrails and do not create impermissible barriers to access.

G. Prime & Subcontractor Authorization Alignment

Prime MCPs and their subcontractors must align all standards and Policies and Procedures related to authorizations for ECM and Community Supports, including both the adjudication standards and the documentation used for referrals and authorizations.

H. Automatically Authorizing ECM for Members Who Receive ECM and Change their Plan Selection/Enrollment

Full Continuity of Care requirements (see APL 18-008 or superseding APL) do not apply to ECM managed care benefit.
However, Medi-Cal managed care Members who were receiving ECM in their previous MCP should continue receiving ECM when they enroll in a new MCP. As such, the new MCP must automatically authorize ECM for a newly enrolled Member if any the following conditions apply:

1. The previous MCP informs the new MCP that the Member received ECM during the last 90 days of enrollment in the previous MCP and did not subsequently either meet graduation criteria or choose to discontinue ECM;
2. Historical utilization data provided to the new MCP by DHCS (referred to as the Plan Data Feed) reveals one or more ECM Healthcare Common Procedure Coding System (HCPCS) codes for ECM services delivered during the last 90 days of enrollment in the previous MCP;
3. The Member, family, or Authorized Representative notifies the new MCP that the Member received ECM during the last 90 days of enrollment in the previous MCP and wishes to continue to do so;
4. The Member's previous ECM Provider notifies the new MCP that the Member received ECM during the last 90 days of enrollment in the previous MCP and recommends continuation of ECM; or
5. The new MCP becomes aware that a newly enrolled Member received ECM during the last 90 days of enrollment in the previous MCP, in any other way.

The new MCP must not implement any other steps to authorize ECM for newly enrolled Members who were receiving ECM in their previous MCP (including obtaining

consent to ECM services) if any of the listed conditions for automatic authorization apply. Rather, the new MCP must assign the Member to an ECM Provider for outreach and continuation of ECM, in accordance with its DHCS- approved ECM Policies and Procedures. To promote smooth transitions, the new MCP must assign the Member to the same ECM Provider, to the extent its network aligns, unless the Member desires to change their ECM Provider.

The new MCP is encouraged to contract with the member's ECM Provider when its network does not align with the member's previous MCP. The new MCP must work with the previous MCP, ECM Provider and/or Member to obtain access to the Member's Care Management Plan and transmit to the new ECM Provider (as applicable) to mitigate any gaps in care. The new MCP should apply its usual Policies and Procedures for reassessment against discontinuation criteria to determine if and when the Member may be stepped down from ECM.

Please note: the above policy applies to ad hoc Member transitions between MCPs. As indicated in APL 23-018 or superseding APL, policies related to the 2024 MCP transition – member transitions due to changes in commercial MCP contracting, Medi-Cal managed care model change, and Kaiser direct contracting that take effect January 1, 2024 – are included in the 2024 MCP Transition Policy Guide.[79]

I. Assignment to an ECM Provider

MCPs will assign every Member authorized for ECM to an ECM Provider. As mentioned above, MCPs are responsible for maintaining a network of ECM providers with the appropriate competencies to serve all populations of focus, and MCPs should aim to assign Members to ECM providers that have the appropriate capacities to meet their needs.

The MCP should prioritize assignment of the Member to a provider that is already known and trusted by the Member. It is possible that the MCP will not always know about these relationships in advance via its own data, so there should be a streamlined process to immediately (re)assign members according to information received from the referral and/or the Member directly, avoiding burden on providers to "prove" the relationship in order to re-assign relative to assignment already conducted via MCP algorithms or similar processes.

[79] The 2024 MCP Transition Policy Guide is available and updated here.

Note that some Members authorized to receive ECM may meet the criteria for multiple Populations of Focus. MCPs will assign these individuals to an ECM Provider that has appropriate competencies and experience for the needs of the Member. For example, individuals with SUD may also be people experiencing homelessness. These Members may be assigned to an ECM Provider that has the necessary skills and experience to work with SUD and homeless populations.

MCPs will develop a process to disseminate information about assigned Members to ECM Provider(s) on a regular cycle and will ensure that communication of Member assignment to the designated ECM Provider occurs within ten (10) business days of authorization. MCPs are also required to document the Member's ECM Lead Care Manager, who will serve as the point of contact for the Member, in its system of record.

Listed below are additional guidelines for the ECM Provider assignment process.

1. Member Pre-Existing Care Management Program (applies to Members enrolled in a pre-existing care management program(s) at the time of ECM enrollment)

MCPs should contract with existing programs that provide care management services to ECM Populations of Focus and could serve as ECM Providers.

- If the Member is enrolled in an existing care management program (such as CCS, SMHS ICC, etc.) that the MCP has contracted with to be an ECM Provider, then the MCP **must** assign the Member to that existing care management program as the ECM Provider **unless** the Member (and/or parent, guardian, caretaker) indicates otherwise.
- If there are multiple existing care management programs that have been contracted with by the MCP to be ECM Providers (e.g., the Member is in both CCS and ICC, and both programs are contracted ECM Providers), then the MCP **must** assign the Member to the existing care management program the Member (and/or parent, guardian, caretaker) identifies as their **preferred** ECM Provider.
    - The assigned ECM Provider is responsible for coordinating with the Member's other care managers and the MCP to ensure non– duplication of services

- If the Member's existing care management program chooses not to serve as the ECM Provider, then the MCP:
- Must assign the Member to an ECM Provider **AND**
- Must ensure the Member receives ECM services **AND** does not receive duplicative care management services or be subject to processes that duplicate what the existing model is already doing (e.g., screening and assessment) **AND**
- Must regularly check available data feeds and establish processes and requirements to identify and eliminate any duplication of services.

2. Member Preference

If Member preference for a specific ECM Provider is known to the MCP, the MCP must honor that preference when assigning the ECM Provider, to the extent practicable.

Further, MCPs must permit Members to change ECM Providers at any time and are expected to implement any requested ECM Provider change within 30 days to the extent the requested ECM Provider is able to accommodate the change.

3. Member PCP

If the Member's assigned PCP is a contracted ECM Provider, the MCP must assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. The MCP must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) business days of the date of assignment.

4. Member Behavioral Health Provider

If a Member receives services from an MHP or DMC/DMC-ODS for SUD and/or serious mental health needs, and the Member's behavioral health Provider is a contracted ECM Provider, the MCP must assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or the MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

J. Initiating Delivery of ECM

1. Member Consent

MCPs must not require ECM Providers or their own staff to obtain Member (and/or parent, guardian, caretaker) consent to participate (in writing or otherwise) as a condition of initiating delivery of ECM, unless required by federal law. DHCS removed documentation requirements to streamline and simplify implementation of the ECM managed care benefit. However, an individual may decline to engage in or continue ECM at any time.

2. Written Authorization for ECM-related Data Sharing[80]

MCPs are not required to obtain Member (and/or parent, guardian, caretaker) authorization (in writing or otherwise) for data sharing as a condition of initiating delivery of ECM, unless such authorization is required by federal law. MCPs must develop Policies and Procedures with their Network of ECM Providers to:

- Where required by federal law, ensure that Members (and/or parents, guardians, caretakers) authorize information sharing with the Contractor and all others involved in the ECM Member's care as needed to support the Member and maximize the benefits of ECM.
- Communicate Member-level (and/or parent-, guardian-, caretaker- level) record of written authorization to allow data sharing (once obtained) back to the MCP.

3. Dedicated Lead Care Manager

MCPs are required to ensure that each Member receiving ECM has a dedicated Lead Care Manager with responsibility for interacting directly with the Member and/or family, Authorized Representatives, caretakers, and/or other authorized support person(s), as appropriate. The assigned Lead Care Manager is responsible for engaging with a multi- disciplinary care team to identify gaps in the Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, Community Supports and other services that address SDOH, regardless of setting, at a minimum. DHCS is not providing

[80] Written authorization for ECM-related data sharing may be obtained from any Member's personal representative as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule 45 CFR § 164.502(g). Under the Rule, a "personal representative" is any person authorized (under State or other applicable law, e.g., tribal or military law) to act on behalf of the individual in making health care related decisions. Refer to HHS for more information.

required staffing ratios for the number of Members who can be served by each care manager at this time.

4. Member-level Records

MCPs are required to ensure that accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

K. Discontinuing Delivery of ECM

1. Circumstances for Discontinuing ECM

Members are able to decline or end ECM upon initial outreach and engagement, or at any other time. Further, MCPs maintain full utilization management authority for ECM, as noted earlier in this Section. ECM Providers will be required to notify MCPs to discontinue ECM for Members when any of the following circumstances are met:

- The Member has met all care plan goals;
- The Member is ready to transition to a lower level of care;
- The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage (this can include instances when a Member's behavior or environment is unsafe for the ECM Provider); or
- The ECM Provider has not been able to connect with the Member and/or parent, caregiver, guardian after multiple attempts.

This can occur at any time and not just at the end of an authorization period. Continuing ECM Services when any of the following circumstances above are met raise fraud, waste and abuse.

2. Reassessment & Transitioning Members from ECM

As mentioned in Section V. Core Service Components of ECM, there is not a required annual reassessment for Members receiving ECM. Instead, MCPs must ensure that Members are reassessed at a frequency appropriate for their individual progress or changes in needs and/or as identified in the Care Management Plan. ECM care managers must also regularly assess members for graduation and proactively notify the MCP when any of the graduation criteria listed above are met. Further, MCPs should reassess Members against their ECM discontinuation criteria, **not** the ECM Population of Focus eligibility criteria, to evaluate whether Members are ready to

transition out of ECM. MCPs must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.

3. NOA Process

MCPs are required to develop processes to determine discontinuation of ECM and notify ECM Providers to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and APL 21-011 or superseding APL.

MCPs must notify the Member of the discontinuation of ECM and ensure the Member is informed of their right to appeal and the appeals process by way of the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and APL 21-011 or superseding APL.

4. Dosage and Outcomes (Added September 2026)

Evidence-based care management models demonstrate that providing three or more encounters per month is associated with stronger member engagement, improved health outcomes, and reductions in avoidable utilization.[81] While the appropriate level of service intensity may vary by population of focus and member needs, consistent and proactive engagement remains foundational to effective ECM delivery. **Therefore, ECM service delivery expectations emphasize achieving an average of three or more encounters per month, so Members who need ECM can fully benefit from the model.**

MCPs are expected to align payment, expectations, and oversight to the actual intensity of services and quality of care delivered. Additional resources and information that MCPs and ECM providers may find helpful when aligning payment to value will be

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[81] Mueller, Luke, Neil Batlivala, Jonathan Palisoc, Connie Kim, Andrey Ostrovsky, Michael Ong, and Nathan Favini. "A Novel Intervention for Medicaid Beneficiaries with Complex Needs: Mueller et al." *Journal of General Internal Medicine* 41, no. 5 (2026): 1222-1228.
Pourat, Nadereh, Emmeline Chuang, Brenna O'masta, Leigh Ann Haley, Xiao Chen, Weihao Zhou, and Menbere Haile. "Final Evaluation of California's Whole Person Care (WPC) Program." *UCLA Center for Health Policy Research* 661 (2022).

included in a forthcoming ECM Payment Resource. This resource details DHCS's rate-development process and service delivery assumptions for ECM.

In addition to ensuring Members who need ECM receive high touch, person centered services, MCPs and ECM providers should consistently evaluate whether Members require and receive appropriate ECM services. MCPs should ensure ECM is provided only to Members whose care needs and service engagement are aligned with ECM managed care benefit's high-intensity design, and should discontinue ECM for Members whose care needs and service engagement are not aligned with ECM care models. Allowable reasons for discontinuing ECM services and required procedures are detailed in Section VIII. Engaging Members in ECM. These individuals should graduate to the appropriate level of care management to meet their needs.

IX. DATA SYSTEM REQUIREMENTS & DATA SHARING TO SUPPORT ECM

The vision of ECM is to embrace and integrate a greater diversity of non-traditional Providers in the delivery of whole-person care. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this vision from an information technology infrastructure and data sharing perspective. To that end, DHCS has developed comprehensive guidance to support standardized information exchange, increase efficiency and reduce administrative burden between MCPs and ECM and Community Supports Providers. See the Member Level Information Sharing Between MCPs and ECM Providers guidance document for a comprehensive overview of the standards for data exchange between MCPs and ECM Providers. In addition, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and ECM Providers.

A. Data System Requirements

MCPs are required to have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in ECM Contract Template Section 7: Identifying Members for ECM, to identify Populations of Focus;
- Ingest, and utilize ADT feed data (effective January 1, 2023);
- Assign Members to ECM Providers;

- Keep records of Members receiving ECM and authorizations necessary for sharing Personally Identifiable Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;
- Securely share data with ECM Providers and other Providers in support of ECM;
- Receive, process and send encounters and invoices from ECM Providers to DHCS in accordance with DHCS standards;
    - Receive and process supplemental reports from ECM Providers;
    - Send ECM supplemental reports to DHCS; and
    - Open, track and manage referrals to Community Supports Providers.

B. Data Sharing Requirements for MCPs

In order to support ECM, MCPs must provide, at a minimum, the following information to all ECM Providers:

- Member assignment files, which include a listing of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
- Historical encounters/claims data for assigned Members;
- ADT feed data within 24 hours of admission, transfer, or discharge (if an ADT feed is available), unless the MCP has verified the ECM Provider has ADT feed data already accessible through another source (effective January 1, 2023);
- Physical, behavioral and administrative information, and information indicating Member SDOH needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS) for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and state standards, specifications, code sets and terminologies when sharing physical, behavioral, social and administrative data with ECM Providers and with DHCS. See the Member Level Information Sharing Between MCPs and ECM Providers guidance document for a comprehensive overview of the standards for data exchange between MCPs and ECM Providers. See Appendix G for more information about the guidance documents referenced in this section.

C. Data Sharing Requirements for ECM Providers

DHCS' vision is that ECM Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs.

DHCS is not specifying the payment model between MCPs and Providers for ECM, though DHCS encourages plans and Providers to adopt or progress to value-based payment models for ECM. Regardless of payment model or reimbursement modality, MCPs are expected to collect encounters from Providers for submission to DHCS.

X. OVERSIGHT OF ECM PROVIDERS

A. MCP Requirements

MCPs are required to perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in the ECM and Community Supports Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use ECM Provider Standard Terms and Conditions to develop ECM contracts with ECM Providers and are expected to incorporate all ECM Provider requirements reviewed and approved by DHCS as part of their MOC, including all monitoring and reporting criteria. To streamline the ECM implementation:

- MCPs must hold ECM Providers responsible for the same reporting requirements as those that the MCP must report to DHCS.
- MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting.
- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of ECM Providers.
- MCPs are recommended to do case/chart level audits regularly to ensure the providers are meeting ECM Provider requirements.

1. NCQA Accreditation Requirements

In order to maximize ECM and Community Supports Provider networks and ease provider burden, the ECM Community Supports Contract Section 3.h specifies that the MCP *"shall not require eligible ECM Providers to be NCQA certified or accredited as a*

condition of contracting as an ECM Provider." Additionally, MCPs must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

All MCPs must be NCQA accredited by 2026. DHCS understands that MCPs may need to meet NCQA requirements as they pertain to their delivery of CCM and that it can be helpful to NCQA and the MCPs if the state clarifies its position in formal guidance.

The below framework and core principles may be used by MCPs in their efforts on meeting NCQA accreditation.

1. A MCP may, or may not, choose to integrate the CCM program with ECM by delegating CCM functions to community-based ECM Providers. The MCP may decide to retain the CCM functions as MCP-operated functions, and keep the ECM functions separate and distinct.
2. If the MCP decides to retain the CCM functions, rather than delegating them to community-based ECM Providers, then CCM would not be considered to be delegated, and no CCM pre-delegation review activities would be required for community-based ECM Providers.
3. However, if the MCP decides to delegate CCM functions to ECM Providers, then these ECM Providers would be subject to CCM pre-delegation review requirements.
4. If the MCP delegates CCM, then the pre-delegation review would be the responsibility of the MCP. States may take on this responsibility in other parts of the country, but California will not do this.

DHCS continues to finalize guidance for ECM as it relates to NCQA and will make updates to the ECM Policy Guide as necessary.

Training

As previously stated, MCPs must notify all Providers in their network about ECM and Community Supports to enable appropriate referrals of their Members. MCPs must also provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars and/or calls, as necessary, in addition to Network Provider training requirements described in Medi-Cal Boilerplate Template, Exhibit A,

Attachment 7, Provision 5, Network Provider Training.[82] MCPs should use their key performance indicators tracking referral patterns to inform what additional trainings may be necessary.

B. Subcontracting Agreements

MCPs may subcontract with other entities to administer ECM, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served; and
- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation.

It is well understood by DHCS that primary plans and Subcontractors have different Provider networks. However, DHCS will hold the primary MCP accountable for the requirements of ECM and Community Supports. DHCS will assess the combined network of the primary MCP and Subcontractors for sufficiency and will hold the primary MCP responsible.

MCPs may also choose to delegate ECM to Independent Physician/Provider Associations (IPAs), Medical Groups and Management Service Organizations (MSOs).

[82] See Medi-Cal MCP Boilerplate Contracts Template.

MCPs must describe these arrangements in the MOC for DHCS approval. IPAs and MSOs must meet all requirements.

MCPs will ensure their Subcontractor agreements for ECM and Community Supports services include the requirements set forth in the ECM and Community Supports Contract Template, and the ECM Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to ECM to minimize variance in how ECM will be implemented and to ensure a streamlined, seamless experience for ECM Providers and Members.

XI. DHCS OVERSIGHT OF ECM

A. Model of Care (MOC) and Approval Process

The ECM MOC is each MCP's framework for providing ECM. Each MCP's MOC includes its overall approach to ECM; its detailed Policies and Procedures with regard to ECM Provider (including non-traditional Provider) contracting and oversight; its ECM and Provider network capacity[83]; and the contract language that will define key aspects of its arrangements with its ECM Providers.

DHCS uses each MCP's MOC submission to determine its readiness to meet ECM requirements ahead of new ECM Populations of Focus being implemented. MCPs must also submit to DHCS any significant changes to their MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable DHCS APLs.

Significant changes may include, but are not limited to, changes to the MCP's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements boilerplates.

[83] ECM Provider Exceptions are over as of June 2024. MCPs may continue to request exception from the JI ECM Provider network overlap requirement between MCPs in the same county; please reference CalAIM-JI-Policy-and-Operations-Guide-Foundational-Guidance for additional information.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

B. Use of Data to Monitor ECM

DHCS is taking a data driven approach to its oversight of ECM.

DHCS will review encounter data submitted by MCPs to monitor the overall reach of ECM. MCPs must submit all ECM encounters to DHCS using national standard specifications and code sets defined by DHCS, including the HCPCS codes established in the ECM and Community Supports HCPCS Coding Guidance. MCPs will be responsible for submitting all encounter data for ECM services provided to its Members, regardless of the number of levels of delegation and/or sub-delegation. MCPs must also require their contracted ECM Providers to submit claims for the provision of ECM services using the national standard specifications and code sets established in the ECM and Community Supports HCPCS Coding Guidance.

Furthermore, MCPs may not require or allow ECM and Community Supports Providers to report codes or modifiers for ECM and Community Supports services beyond those included in the ECM and Community Supports HCPCS Coding Guidance, even if the MCP and ECM/Provider mutually agree to the additional codes/modifiers. [84] As mentioned above in Data System and Data Sharing Requirements to Support ECM, in the event the ECM Provider is unable to submit ECM encounters using the national standard specifications and code sets defined by DHCS, the MCP will be responsible for converting the ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS. DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract, APL 14-019 or superseding APL, and the ECM & Community Supports Billing & Invoicing guidance document. See Appendix G for more information about the guidance documents referenced in this section.

[84] DHCS is working individually with select MCPs who are currently allowing or requiring additional codes/modifiers beyond those established by DHCS. If your organization has any questions about the DHCS-established ECM and Community Supports HCPCS codes, please email: EnhancedCareManagement@dhcs.ca.gov or CommunitySupports@dhcs.ca.gov.

C. JSON Monitoring Process (Updated September 2026)

Beginning in January 2024, DHCS is transitioning the quarterly reporting performed via the Quarterly Implementation Monitoring Report (QIMR) Excel Reports by requiring additional monthly JSON file submissions. JSON, or JavaScript Object Notation, is an open standard file format that streamlines the collection and transmission of implementation data and is utilized by the Department for other mandatory reporting purposes.

As part of DHCS's continued work to streamline data reporting and improve data quality across programs:

- DHCS **discontinued** the acceptance of the Quarterly Implementation Monitoring Report (QIMR) files after August 14, 2026, when the final Q2 2026 QIMR submission was due.
- After completing this final QIMR Submission, MCPs will be required to exclusively submit their **monthly ECM/Community Supports JSON submissions and their 837 encounter transactions** for all ECM/Community Supports reporting purposes.
- To support high-quality monitoring, evaluation, and program integrity, MCPs must ensure that all ECM and Community Supports JSON files and 837 encounter transactions submitted to DHCS are accurate, complete, internally consistent, and aligned with each other. Following DHCS's retirement of the Quarterly Implementation Monitoring Report (QIMR) after the final Q2 2026 submission, monthly JSON files and 837 encounters serve as the sole official data sources for ECM/Community Supports reporting, including but not limited to publicly reported dashboards, Federal and statewide reporting required for CMS and DHCS compliance and funding, program monitoring, evaluation, and planning activities driving quality improvement and future program decisions, service integration and coordination, network capacity, provider relations, and member growth and experience. Timely completion and accurate data submission supports DHCS in collecting accurate ECM data.

DHCS has produced accompanying Technical Documentation through an available Technical Assistance Companion Guide, containing all of the technical information (including data dictionaries, file layouts, JSON Schemas, and details on response files) required for MCPs to be able to submit one data file to DHCS monthly. A Data Dictionary is also available, describing the required data values as well as the validation edits performed on specific data elements. Both technical documentation

resources are available online in the DHCS Documentation Center and MCPs seeking access to these resources should contact EDIMdatasupport@dhcs.ca.gov.

DHCS may conduct detailed audits of MCPs and ECM as part of the annual audit process and /or other focused audits.

D. Requirements to Track Outreach

The MCP contract specifies that "Contractor shall track and report to DHCS, in a format to be defined by DHCS, information about outreach efforts related to potential Members to be enrolled in ECM". The ECM and Community Supports Coding Options guidance document includes HCPCS codes MCPs must use to submit encounters for ECM outreach attempts. MCPs must submit outreach data via monthly JSON submissions. In addition to this monthly report, MCPs will, upon DHCS request, provide information about outreach for rate setting purposes by way of the Supplemental Data Request (SDR) process. Within the Member-Level Information Sharing Between MCPs and ECM Providers guidance document, DHCS lays out standards for outreach tracking at the Provider level to create consistency in the way Providers are being asked to track the information and share it with multiple MCPs. This set of standards is called the "ECM Provider Initial Outreach Tracker File."

E. ECM Provider Reporting in 274

In order to monitor ECM and Community Supports Providers on an ongoing basis, DHCS will require MCPs to report ECM Providers in the 274 Provider file, beginning upon implementation. Guidance related to reporting ECM Providers in the 274 Provider file is forthcoming.

XII. APPENDICES

Appendix A: ECM Implementation Dates by County

Counties with WPC Pilots and/or HHP (Begin ECM implementation on 1/1/22)	Program	Counties without WPC Pilots and/or HHP (Begin ECM implementation on 7/1/22)	Counties without WPC Pilots and/or HHP, Continued (Begin ECM implementation on 7/1/22)
Alameda	HHP, WPC	Alpine	Solano
Contra Costa	WPC	Amador	Stanislaus
Imperial	HHP	Butte	Sutter
Kern	HHP, WPC	Calaveras	Tehama
Kings	WPC	Colusa	Trinity
Los Angeles	HHP, WPC	Del Norte	
Marin	WPC	El Dorado	
Mendocino	WPC	Fresno	
Monterey	WPC	Glenn	
Napa	WPC	Humboldt	
Orange	HHP, WPC	Inyo	
Placer	WPC	Lake	
Riverside	HHP, WPC	Lassen	
Sacramento	HHP, WPC	Madera	
San Bernardino	HHP, WPC	Mariposa	
San Diego	HHP, WPC	Merced	

Counties with WPC Pilots and/or HHP (Begin ECM implementation on 1/1/22)	Program	Counties without WPC Pilots and/or HHP (Begin ECM implementation on 7/1/22)	Counties without WPC Pilots and/or HHP, Continued (Begin ECM implementation on 7/1/22)
San Francisco	HHP, WPC	Modoc	
San Joaquin	WPC	Mono	
San Mateo	WPC	Nevada	
Santa Clara	HHP, WPC	Plumas	
Santa Cruz	WPC	San Benito	
Shasta	WPC	San Luis Obispo	
Sonoma	WPC	Santa Barbara	
Tulare	HHP	Sierra	
Ventura	WPC	Siskiyou	

Appendix B: Access Criteria for SMHS, DMC-ODS, and DMC

SMHS Access Criteria: BHIN 21-073 or superseding BHIN updates and clarifies the criteria for access to SMHS, both for adults and beneficiaries under age 21.

- For beneficiaries 21 years of age or older, a county MHP shall provide covered SMHS for beneficiaries who meet **BOTH of the following criteria**:
    - The beneficiary has one or both of the following:
        - Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; and/or
        - A reasonable probability of significant deterioration in an important area of life functioning; AND
    - The beneficiary's condition as described is due to either of the following:
        - A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; or
        - A suspected mental disorder that has not yet been diagnosed.
- For enrolled beneficiaries under 21 years of age, a county MHP shall provide all medically necessary SMHS required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered SMHS shall be provided to enrolled beneficiaries who meet **either of the following criteria**, (1) or (2) below:
    - (1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness; OR
    - (2) The beneficiary meets both of the following requirements in a) and b), below:
        - a) The beneficiary has at least one of the following:
            - A significant impairment

        - A reasonable probability of significant deterioration in an important area of life functioning A reasonable probability of not progressing developmentally as appropriate.
        - A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a MCP is required to provide; AND
    - b) The beneficiary's condition as described in subparagraph (2) above is due to **one of the following:**
        - A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
        - A suspected mental health disorder that has not yet been diagnosed.
        - Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

DMC-ODS Access Criteria: BHIN 21-019 or superseding BHIN clarifies the policy related to access to treatment during the initial assessment period, medical necessity determination, and level of care placement for DMC-ODS. Within non- residential treatment settings, which includes mobile crisis services, DMC- ODS services are reimbursable for up to 30 days following a visit with a Licensed Professional of the Healing Arts (LPHA) or registered/certified counselor, whether or not a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the beneficiary is under 21 if a Provider documents that the beneficiary is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis, the time period starts over.

- To qualify for DMC-ODS services after the initial assessment, beneficiaries 21 years of age or older must meet one of the following criteria:
    - Have at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non Substance-Related Disorders; OR

- Have had at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders, prior to being incarcerated or during incarceration, as determined by substance use history.

» Beneficiaries under age 21 are entitled to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid- coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

DMC Services Medical Necessity Criteria: Providers must ensure that Members meet and document the medical necessity criteria for DMC services, further details can be found in California Code of Regulations, Title 22, § 51341.1

Appendix C: Definitions for the Purposes of the Justice-Involved Population of Focus

Criteria	Definition
Mental Illness	A person with a mental illness is a person who is currently receiving mental health services or medications OR meets both of the following criteria: i. The member has one or both of the following: a. Significant impairment, where "impairment" is defined as distress, disability, or dysfunction in social, occupational, or other important activities. b. A reasonable probability of significant deterioration in an important area of life functioning. ii. The beneficiary's condition as described in the bullet above is due to either of the following: a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems. b. A suspected mental disorder that has not yet been diagnosed
Substance use Disorder (SUD)	A person with a SUD is a person who either: i. Meets the criteria for an SUD as defined in the current editions of the DSM and/or the *International Statistical Classification of Diseases and Related Health Problems*. ii. Has a suspected SUD diagnosis that is currently being assessed through either National Institute of Drug Abuse (NIDA)-modified Alcohol, Smoking

Criteria	Definition
	and Substance Involvement Screening Test (ASSIST), American Society of Addiction Medicine (ASAM) criteria.
Chronic Condition / Significant Clinical Condition	Condition, as indicated: » Active cancer; » Active hepatitis A, B, C, D, or E; » Advanced liver disease » Advanced renal (kidney) disease; » Autoimmune disease, including but not limited to rheumatoid arthritis, lupus, inflammatory bowel disease, and multiple sclerosis; » Chronic musculoskeletal disorders that impact functionality of activities of daily living, including but not limited to arthritis and muscular dystrophy; » Chronic neurological disorder; » Severe chronic pain » Congestive heart failure » Connective tissue disease » Coronary artery disease; » Currently prescribed opiates or benzodiazepines; » Currently undergoing a course of treatment for any other diagnosis that will require medication management of three or more medications or one or more complex medications that requires monitoring (e.g. anticoagulation) therapy after reentry; » Cystic fibrosis and other metabolic development disorders; » Epilepsy or seizures; » Foot, hand, arm, or leg amputee; » Hip/pelvic fracture;

Criteria	Definition
	» HIV/AIDS; » Hyperlipidemia; » Hypertension; » Incontinence; » Severe migraine or chronic headache; » Long COVID-19; » Moderate to severe atrial fibrillation/arrhythmia; » Moderate to severe mobility or neurosensory impairment (including, but not limited to spinal cord injury, multiple sclerosis, transverse myelitis, spinal canal stenosis, peripheral neuropathy); » Obesity; » Peripheral vascular disease; » Pressure injury or chronic ulcers (vascular, neuropathic, moisture-related); » Previous stroke or transient ischemic attack; » Receiving gender affirming care; » Active respiratory conditions, such as severe bronchitis, chronic obstructive pulmonary disease (COPD), asthma, or emphysema. Severe viral, bacterial, or fungal infections; » Sickle cell disease or other hematological disorders; » Significant hearing or visual impairment; » Spina bifida or other congenital anomalies of the nervous system; » Tuberculosis; » Type 1 or 2 diabetes.

Criteria	Definition
Intellectual or Developmental Disability (I/DD)	A person with an intellectual or developmental disability is a one who has a disability that begins before the individual reaches age 18 and that is expected to continue indefinitely and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, autism, Down syndrome, and other disabling conditions as defined in Section 4512 of the California Welfare and Institutions Code.
Traumatic Brain Injury (TBI)	A person with a traumatic brain injury, is one with a condition that has caused significant cognitive, behavioral, and/or functional impairment.
HIV/AIDS	A person with HIV/AIDS shall have tested positive for either HIV or AIDS at any point in their life.
Pregnant or Postpartum	A person who is pregnant or postpartum is one who is either currently pregnant or within the 12-month period following the end of pregnancy.

Appendix D: Existing Aid Codes and Eligibility Groups for Children and Youth Involved in Child Welfare Population of Focus

- Foster Care Enrollment in California Aid Codes:[85]
  - Approved Relative Caregiver (youth in this category are eligible for former foster care youth eligibility group (see below) if they exit foster care at age 18 or older):
    - 2P – Approved Relative Caregiver (ARC) Only
    - 2R – ARC Only for Non-minor Dependents (NMD)
    - 2S – ARC Funding Option and Federal California Work Opportunity and Responsibility to Kids (CalWORKS)
    - 2T – ARC Funding Option and State CalWORKS
    - 2U – ARC and State CalWORKS for NMD
  - Foster Care (other than youth in aid codes 4E and 4M, youth in this category are eligible for former foster care youth eligibility group (see below) if they exit foster care at age 18 or older):
    - 4E – Foster Care Hospital Presumptive Eligibility (PE) (Age 18 to 26 Years)
    - 4H – Foster Care Child in CalWORKs
    - 4K – Emergency Assistance (EA) Foster Care
    - 4L – Foster Care Child in 1931(b)
    - 4M – Former Foster Youth Program (FFY) (see below)
    - 4N – CalWORKs NMD State Cash/FFP Medi-Cal
    - 40 – Aid to Families with Dependent Children (AFDC) Foster Care (FC) – Non-Federal
    - 42 – AFDC - FC – Federal

[85] A child's involvement in foster care would only be identified by these aid codes if they were currently enrolled in foster care. These aid codes do not track former foster care enrollment in California or another state.

        - 43 – AFDC FC NMD State Cash/FFP Medi-Cal
        - 45 – Foster Care
        - 46 – Foster Care – Out of State (OOS) – CA Medi-Cal
        - 49 – AFDC-FC NMD Title IV-E Federal/FFP Medi-Cal
        - 5K – EA Foster Care – Child Welfare Services (CWS) – State Only
        - 5L – EA Foster Care-Non Fed; EA Program
    - Former Foster Care Youth Eligibility Group (youth in this category are eligible if they exist foster care at age 18 or older, regardless of the state they were in foster care, up to age 26 and regardless of income):
        - 4M – Former Foster Youth Program (FFY)
    - Adoption Assistance Program Aid Codes:[86]
        - 03 – Adoption Assistance Program (AAP) – Federal
        - 04 – AAP/Aid for the Adoption of Children (AAC)
        - 06 – AAP/Out of State (OOS) – CA Medi-Cal
        - 07 – AAP NMD Title IV-E/Federal Financial Participation (FFP) Medi-Cal
        - 4A – OOS of State AAP Children

There are no aid nor eligibility codes to track Family Maintenance eligibility or enrollment.

[86] A child's involvement in Adoption Assistance Program would only be identified by these aid codes if they currently were enrolled in the Program. These aid codes do not track eligibility for the Program.

Appendix E: DMC & DMC-ODS Counties (as of January 2026)[87]

DMC Counties	DMC-ODS Counties	DMC-ODS Counties, Continued
Alpine	Alameda	Riverside
Amador	Contra Costa	Sacramento
Butte	El Dorado	San Benito
Calaveras	Fresno	San Bernardino
Colusa	Humboldt	San Diego
Del Norte	Imperial	San Francisco
Glenn	Kern	San Joaquin
Inyo	Lake	San Luis Obispo
Kings	Lassen	San Mateo
Madera	Los Angeles	Santa Barbara
Mono	Marin	Santa Clara
Plumas	Mariposa	Santa Cruz
Sierra	Mendocino	Shasta
Sutter	Merced	Siskiyou
Tehama	Modoc	Solano
Trinity	Monterey	Sonoma
Tuolumne	Napa	Stanislaus
Yuba	Nevada	Tulare

[87] Counties Participating in DMC-ODS.

DMC Counties	DMC-ODS Counties	DMC-ODS Counties, Continued
	Orange	Ventura
	Placer	Yolo

Appendix F: CCS & CCS WCM Counties (as of January 2026)[88]

CCS Counties	CCS WCM Counties	CCS WCM Counties, Continued
Alameda	Butte	Siskiyou
Alpine	Colusa	Solano
Amador	Del Norte	Sonoma
Calaveras	Glenn	Sutter
Contra Costa	Humboldt	Tehama
El Dorado	Lake	Trinity
Fresno	Lassen	Yuba
Imperial	Marin	Yolo
Inyo	Mariposa	
Kern	Mendocino	
Kings	Merced	
Los Angeles	Modoc	
Madera	Monterey	
Mono	Napa	

[88] DHCS CCS WCM webpage.

CCS Counties	CCS WCM Counties	CCS WCM Counties, Continued
Riverside	Nevada	
Sacramento	Orange	
San Bernardino	Placer	
San Diego	Plumas	
San Francisco	San Benito	
San Joaquin	San Luis Obispo	
Santa Clara	San Mateo	
Stanislaus	Santa Barbara	
Tulare	Santa Cruz	
Tuolumne	Shasta	
Ventura	Sierra	

Appendix G: Data & Reporting Guidance Documents

Guidance	Description
Billing & Invoicing Guidance	Standard, "minimum necessary" data elements MCPs will need to collect from ECM or Community Supports Providers unable to submit ANSI ASC X12N 837P claims to MCPs.
Member Information File Guidance	Defines standards for data sharing between MCPs and ECM Providers.
Quarterly Implementation Monitoring Report Guidance	Time-limited quarterly MCP reporting requirements and Excel template related to ECM and Community Supports implementation across multiple domains. They are "supplemental" to encounters.
ECM & Community Supports Coding Options	Contains the HCPCS codes that MCPs must use for ECM and Community Supports services.

Background on CalOptima Health's Enhance Care Management Program

October 1, 2026

Program Model

Community-Based: CalOptima Health has established a diverse network of 62 contracted Enhanced Care Management (ECM) providers with demonstrated expertise serving one or more of the state-defined ECM Populations of Focus as defined on page2Per DHCS, **Enhanced Care Management is a statewide Medi-Cal benefit that addresses the clinical and non-clinical needs of the highest-need Medi-Cal members by building trusting relationships with members and providing intensive coordination of health and health-related services.** Building on this foundation, CalOptima Health has a strong ECM network, with DHCS confirming it met all threshold goals for member utilization growth and provider network capacity.

In-Person Focused: CalOptima Health's ECM network provides broad access to in-person services throughout Orange County, helping providers build trusted relationships with members and deliver care management in the settings most responsive to members' needs. All contracted providers offer in-person ECM services.

ECM Academy

CalOptima Health provides the training, education and ongoing technical support necessary to help providers deliver high-quality, trauma-informed, culturally responsive, person-centered ECM services. Providers participate in the six-month **ECM Academy** and continue to receive support following completion of the Academy to strengthen operational readiness and service delivery

- **The ECM Academy is a six-month intensive training and onboarding program** required for organizations selected to be contracted as ECM providers within CalOptima Health's network.
- **Weekly training sessions address the core competencies required to successfully deliver ECM**, including clinical and program operations, DHCS requirements and compliance, organizational capacity and infrastructure, administrative program requirements and the philosophies of care that underpin the ECM model.
- **To date, CalOptima Health has successfully completed three ECM Academy cohorts, graduated 62 ECM providers** and helped build a diverse, community-based network prepared to meet the needs of our members needing ECM services across Orange County.

Vetting Process

Before entering the ECM Academy, organizations seeking to contract as providers undergo a comprehensive vetting process to assess their readiness, experience, and capacity to deliver ECM services. This process includes:

1. **Review of the submitted CalOptima Health ECM application** to confirm that the organization meets initial eligibility and submission requirements.

2. **Staff research on each applicant organization's mission, experience and areas of expertise**, including its history of serving the communities and populations targeted by ECM.
3. **Assessment of the organization's ability to meet ECM's seven core components and capacity requirements**, including staffing, infrastructure, care coordination, member engagement, data reporting, compliance and service delivery.
4. **In-person interviews with key applicant staff** to further evaluate organizational leadership, operational readiness, clinical capacity, and understanding of the person-centered ECM model.

Provider Network

CalOptima Health's contracted ECM provider network includes 62 organizations with diverse experience, expertise, and community connections. The network is comprised of:

- 54% Community Based Organizations
- 25% Community Health Centers
- 8% Health Networks
- 5% PCP or Hospital
- 8% Other (Street Medicine Provider, Adult Day Health Center, etc.)

Each contracted organization serves at least one population of focus, ensuring broad coverage and access to specialized services across every population category. This diverse network allows CalOptima Health to connect members with providers that understand their unique needs, communities and barriers to care.

DHCS Defined Populations of Focus	Adult	Children
#1 – Individuals and Families Experiencing Homelessness	38	31
#2 – High Utilizers	44	32
#3 – Serious Mental Health/Substance Use Disorder Needs	31	25
#4 – Justice – Involved	9	4
#5 – Long-Term-Care Risk	25	n/a
#6 – Transitioning from Nursing Facility to Community	17	n/a
#7 – California Children's Services/ Whole Child Model	n/a	11
#8 – Child Welfare	n/a	24
#9 – Birth Equity	25	21

In addition, 95% of ECM providers have established brick-and-mortar facilities in Orange County, providing members with accessible, community-based locations for care and support.

Language, Cultural and Community Reach

CalOptima Health's ECM network reflects the linguistic and cultural diversity of Orange County. The network includes community-based organizations and health centers with longstanding relationships and direct service experience within Latino, Vietnamese, Korean, Chinese, broader Asian American and Pacific Islander, immigrant and refugee, LGBTQ+, older adult and other diverse communities.

Across the entire network, providers also offer services through multilingual and bilingual staff, culturally specific programs and community-based outreach. Collectively, ECM organizations demonstrate capacity in languages including Spanish, Vietnamese, Korean, Chinese/Mandarin/Cantonese, Farsi, Arabic, Tagalog, Khmer/Cambodian, Samoan and other languages, with interpreter services available to support additional language needs.

Many ECM providers bring cultural expertise that extends beyond language access. Organizations such as OCAPICA, KCS Health Center, Asian American Senior Citizens Service Center, Southland Integrated Services, ABRAZAR and Casa de la Familia have longstanding histories of serving specific cultural and immigrant communities, while other ECM providers bring specialized experience serving LGBTQ+ individuals, older adults, individuals experiencing homelessness, people with disabilities and other populations with unique health and social needs.
This breadth allows CalOptima Health to connect members with ECM providers that can address not only their clinical and social needs, but also their language, cultural and community preferences.

Outcomes

- **To date, 21,629 unique members have received ECM services**, representing 2.7% of the current membership, and exceeding DHCS's goal of 1% for MCPs.
- **On July 1, 2025, DHCS notified CalOptima Health that it had met its 12-month threshold goals** for member utilization growth and provider network capacity.
- **Since ECM services launched in 2022, CalOptima Health has not had a waitlist for ECM services**, helping ensure timely access for eligible members.

CalOptima Health's ECM Providers

1. Abrazar Inc.
2. AltaMed
3. Alzheimer's Orange County dba Central County Senior Services, LLC
4. American Family Housing
5. Amity Foundation
6. AMVI (Prospect)
7. Asian American Senior Citizens Service Center (AASCSC)
8. Boys & Girls Clubs of Garden Grove
9. Camino Health Center
10. Casa De La Familia
11. Celebrating Life Community Health Center
12. Child Guidance Center, Inc.
13. Children's Hospital Los Angeles (CHLA)
14. CHOC
15. Community Action Partnership of Orange County (CAPOC)
16. Council on Aging-Southern California
17. County (OCHCA)
18. Dr. Patricia's Health Club, Inc.
19. Families Together Orange County
20. FCMG
21. Five Acres
22. Friendship Shelter
23. Global Transitional Care, Inc. dba Care Partners Medicine
24. Healthcare in Action
25. HealthRIGHT 360
26. Heritage Health Network
27. Housing for Health Orange County (HHOC)
28. Human Options
29. Hurtt Family Health Clinic
30. KCS Health Center
31. Koinonia Foster Homes DBA Koinonia Family Services
32. Laguna Adult Day Health Center
33. Libertana
34. Mariposa Center Women and Family
35. Meals on Wheels OC
36. Mindful Living Center California, LLC dba Maximon Behavioral
37. MOMS Orange County
38. Noble
39. NOCRHF (Family Health Matters)
40. Nurturing Care LLC

41. Olive Crest
42. Optum
43. Orange County Asian and Pacific Islander Community Alliance, Inc.
44. Pair Team Medical Group of California, PC
45. PATH
46. Project Kinship
47. Prospect (Prospect)
48. Radiant Health Centers
49. ResolutionCare, PC
50. Rx Consultants Group, Inc
51. Seneca Family of Agencies
52. Serve the People Community Health Center
53. Share Our Selves
54. South Coast Community Services
55. Southland Integrated Services
56. Sowing Seeds Health, Inc.
57. St. Jude Neighborhood Health Centers
58. The Illumination Foundation
59. Titanium Healthcare
60. UCMG (Prospect)
61. VCC: The Gary Center
62. Western Youth Services

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

20. Status Report on the Community Health Worker Benefit for Medi-Cal Members

Contact

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Action

Accept, receive, and file a status report on the Community Health Worker Benefit for Medi-Cal members.

Background

At the October 1, 2026, regular meeting of the CalOptima Health Board of Directors (Board), in response to public comments made by Community-Based Organizations (CBO) regarding the Enhanced Care Management and Community Health Worker (CHW) benefits, Chair Vicente Sarmiento directed staff to agendize an item for the Board to discuss. As such, staff is bringing forth an update and background information on the CHW benefit.

CHW

In May of 2024, the Department of Health Care Services (DHCS), issued All Plan Letter (APL) 24-006 to provide Medi-Cal managed care plans (MCP) with guidance regarding qualification for organizations interested in becoming CHWs. The goal of CHWs is to advance the California Advancing and Innovative Medi-Cal (CalAIM) initiative's efforts in providing equitable health care through culturally competent services and further promote the MCP's contractual obligations to meet DHCS's broader Population Health Management standards.

According to the APL, per State Plan Amendment 22-0001, CHW services are preventive health services as defined in Title 42 Code of Federal Regulations Section 440.130(c). CHW services may assist with a variety of concerns impacting members, including, but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services.

Additionally, CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services. CHWs are often members of the community they serve and link members to health services, social services, and other resources to improve overall quality of health. Qualified CHWs may include promotoras, community health representatives, navigators, and other non-licensed public health workers.

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DHCS also has specific CHW provider requirements and qualifications, including:

- Lived experience that aligns with and provides a connection between the CHW and the member or population being served.
    - This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use disorders, or being a survivor of domestic or intimate partner violence or abuse and exploitation, shared race, ethnicity, and gender, among others.
- Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
    - CHW Certificate: A valid certificate of completion of a curriculum in certain skill and training areas, as specified by DHCS.
    - Violence Prevention Professional Certificate: A certificate issued by the Health Alliance for Violence Intervention or Urban Peace Institute demonstrating violence prevention training.
    - Work Experience Pathway: An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years.
- Additional training: CHWs must complete a minimum of six hours of additional relevant training annually, which can be in the core competencies or specialty area.

CHWs are required to document the dates and time/duration of services provided to members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. For example, documentation might state, “Discussed the patient’s challenges accessing healthy food and options to improve the situation for 15 minutes.”

In addition to specifying CHW provider requirements and qualifications, the APL also lists non-covered CHW services, including:

- Clinical case management that requires a license
- Childcare
- Employment services
- Helping a member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
- Transportation
- Services that duplicate another covered Medi-Cal service that is already being provided to a member

Discussion

CalOptima Health executed a phased approach to develop a sustainable and forward-thinking implementation strategy for the CHW benefit.

- **Phase 1- Co-Design Pilot:** Identified and contracted with five (5) CBOs that have robust CHW expertise and experience to inform and co-design the implementation of the CHW benefit. The pilot was a five-month process comprised of collaborative meetings with the CBOs that identified best practices for CHW services, training approaches, CBO needs, and internal and external workflows.
- **Phase 2- Expand Network with the CHW Academy:** Developed and launched Notice of Funding Opportunity (NOFO) to support the selection of additional organizations to participate

in a six-month CHW Academy and be trained as CHW supervising providers. A total of 45 organizations applied for the NOFO, and CalOptima Health chose 16 CBOs to participate in the CHW Academy, alongside the five (5) previously contracted CBOs.

The CHW Academy was a six-month training and onboarding program, comprised of 22 training modules, that reviewed the core components of the CHW benefit, including DHCS requirements, CHW training, certification pathway options, billing, workforce sustainability, and organizational infrastructure development. CalOptima Health required participation in the CHW Academy prior to contracting with organizations to provide CHW services. All 21 organizations participating in the CHW Academy graduated from the CHW Academy, and CalOptima Health then contracted with these organizations to provide CHW services as of December 2025.

Recently, CalOptima Health has received several questions on strategies to improve the CHW benefit, including network restrictions, financial impact, data sharing, and transparency. After the October 2026 Board meeting, CalOptima Health invited all of the CBOs who provided public comment to an in-person meeting on October 26th 2026 to further discuss these questions and strategies.

Network Restrictions

Currently, CBOs are only authorized to directly bill for services provided to members of CalOptima Health Community Network Expansion and CalOptima Health Community Network (CCN). CHW is a delegated benefit. Staff will work with health networks to identify avenues that expand the availability of the benefit across networks.

Reimbursement Rate

CalOptima Health reimburses the CHW benefit at the DHCS-approved baseline rate of $26.66 per 30-minute unit of service. Staff is assessing reimbursement rates among peer health plans to evaluate potential rate flexibility.

Data Sharing and Transparency

DHCS required CalOptima Health to report CHW utilization data for all delegated health networks from Quarter 1 2024 – Quarter 2 2025. After that point, DHCS no longer required data collection and reporting from the heath networks. CalOptima Heath tracks utilization data for CCN and CalOptima Direct (COD) members. Since 2022, approximately 20,122 unique CCN/COD members have received CHW services. Based on community input, starting Quarter 1 2027, CalOptima Health will begin tracking health network CHW utilization for internal monitoring and will report out both the CNN/COD and health network CHW utilization data in the CalAIM report provided at the quarterly Finance Advisory Committee meeting.

Fiscal Impact

The recommended action has no additional fiscal impact.

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Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. DHCS APL 24-006
2. Background on CHW Program Summary

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: May 13, 2024

ALL PLAN LETTER 24-006
SUPERSEDES ALL PLAN LETTER 22-016

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: COMMUNITY HEALTH WORKER SERVICES BENEFIT

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance regarding the qualifications for becoming a Community Health Worker (CHW), the definitions of eligible populations for CHW services, and descriptions of applicable conditions for the CHW benefit.

BACKGROUND:
Per State Plan Amendment (SPA) 22-0001, CHW services are preventive health services as defined in Title 42 Code of Federal Regulations (CFR) Section 440.130(c).[1,2] CHW services may assist with a variety of concerns impacting Members, including but not limited to, the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and need for preventive services. Additionally, CHW services can help Members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services. CHWs tend to be members of the community they serve and link Members to health and social services to improve overall quality of services delivered.

CHW services are defined as preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHWs may include individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, with the qualifications specified below.

Through their community connection and engagement, CHWs will advance the

[1] See 42 CFR 440.130(c). The CFR is searchable available at: https://www.ecfr.gov/
[2] SPA information is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx

California Advancing and Innovating Medi-Cal (CalAIM) initiative's efforts in providing equitable health care through culturally competent services and further promote the MCP's contractual obligations to meet Department of Health Care Services' (DHCS) broader Population Health Management (PHM) standards.[3] [4] MCPs may have already begun to employ CHWs to implement a wide array of activities, including support for Basic Population Health Management (defined as an approach to care that ensures needed programs and services, including primary care, are made available to each Member at the right time and in the right setting) and support for Transitional Care Services (defined as Members transferring from one setting or level of care to another), particularly when Members are discharged back to a home or a community-based setting. CHWs may also already perform a care management role in Enhanced Care Management (ECM).[5] The CHW services benefit described in this APL provides a mechanism for providing and reimbursing for services provided by CHWs. MCPs are not precluded from continuing to leverage CHWs in-house at the MCP or otherwise outside the scope of this benefit. In the case of CHWs performing a role in ECM, however, Providers may not bill for both ECM and the CHW benefit for the same Member, as described below.

POLICY:

CHW Provider Requirements and Qualifications

Required CHW Minimum Qualifications**:**

CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population being served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use disorders, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services. Supervising Providers (the organizations employing or otherwise overseeing the CHWs with which the MCP contracts, as described below) are encouraged to work with CHWs who are familiar with and/or have experience in the geographic communities

[3] More information regarding CalAIM is available at: https://www.dhcs.ca.gov/calaim
[4] More information on PHM is available at https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx, including in the PHM Program Guide.
[5] See APL 23-032, Enhanced Care Management Requirements. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

they are serving. Supervising Providers must maintain evidence of this experience. CHWs must demonstrate, and Supervising Providers must maintain evidence of, minimum qualifications through one of the following pathways, as determined by the Supervising Provider:

- Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:

    - **CHW Certificate:** A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH), as determined by the Supervising Provider.[6] Certificate programs must also include field experience as a requirement.

      A CHW Certificate allows a CHW to provide all covered CHW services described in this APL, including violence prevention services.

    - **Violence Prevention Professional Certificate**: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training form the Urban Peace Institute.[7,8]

      A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or by completion of a General Certificate.

[6] DHCS previously used the term "Social Determinants of Health" and has since shifted to "Social Drivers of Health".
[7] More information regarding Health Alliance for Violence Intervention is available at: https://www.thehavi.org/.
[8] More information regarding Urban Peace Institute is available at: https://www.urbanpeaceinstitute.org/.

- **Work Experience Pathway:** An individual who has at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and has demonstrated skills and practical training in the areas described above, as determined and validated by the Supervising Provider, may provide CHW services without a certificate of completion for a maximum period of 18 months. A CHW who does not have a certificate of completion must earn a certificate of completion, as described above, within 18 months of the first CHW visit provided to a Member.

CHWs must complete a minimum of six hours of additional relevant training annually, which can be in the core competencies or specialty area. The Supervising Provider must maintain evidence of this training. Supervising Providers may provide and/or require additional training, as identified by the Supervising Provider.

CHW Service Provision During the Following Emergency Department Visits and Encounter Data

No later than March 2025, MCPs are required to have approved and operable policies and procedures (P&Ps) to effectuate a billing pathway for Supervising Providers, including contracted hospitals, to claim for provisions of CHW services to Members during an emergency department visit and/or as outpatient follow-up to an emergency department visit. The billing pathway may be structured as a sub-capitated rate, an add-on rate to existing payments, or another billing and payment arrangement agreed upon with the Provider. Claims processes must adhere to contractual requirements related to claims processing and encounter data submissions including use of approved codes pursuant to the Medi-Cal Provider Manual for CHW Preventive Services.[9] Please refer to the "Member Eligibility Criteria for CHW Services" section of this APL for recommendation requirements for CHW services. MCPs must report all CHW service encounters to DHCS.

Supervising Provider:

A Supervising Provider is an enrolled Medi-Cal provider employing or otherwise overseeing the CHW, with which the MCP contracts. The Supervising Provider ensures that CHWs meet the qualifications listed below in this APL, oversees CHWs and the services delivered to MCP Members, and submits claims for services provided by CHWs. The Supervising Provider must be a licensed Provider, a hospital, including the

[9] The CHW Preventive Services Medi-Cal Provider Manual is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/03BBA223-8762-4A94-A268-209510E15E37/chwprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

emergency department, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).[10] MCPs must not require Supervising Providers to have a licensed Provider on staff in order to contract with the MCP to bill for CHW services.

The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services. Supervising Providers do not need to be physically present at the location when CHWs provide services to Members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.
Supervising Providers must provide direct or indirect oversight to CHWs. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of a plan of care, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.

MCPs must ensure that Supervising Providers or their Subcontractors contracting with or employing CHWs to provide covered CHW services to Members verify that CHWs have adequate supervision and training.

Member Eligibility Criteria for CHW Services
CHW services require a written recommendation submitted to the MCP by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. For CHW services rendered in the Emergency Department, the treating Provider may verbally recommend CHWs to initiate services and later document the recommendation in the Member's medical record of the Emergency Department visit. The recommending licensed Provider does not need to be enrolled in Medi-Cal or be a Network Provider within the Member's MCP or employed by the Supervising Provider. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers,

[10] See Provider Bulletin on Medi-Cal Enrollment Requirements for CBOs and LHJs: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/page/community-based-organizations-and-local-health-jurisdictions-enrollment

licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

- The required recommendation can be provided by a written recommendation placed in the Member's record or a standing recommendation by the MCP based on eligibility criteria for CHW services as described in the Medi-Cal Provider Manual.

Please note that while a recommendation for CHWs services is required to be submitted to MCPs, MCPs must not require prior authorization for CHW services as preventive services for the first 12 units, as described in the section below on "Billing, Claims, and Payments."

The recommending licensed Provider must ensure that a Member meets eligibility criteria before recommending CHW services. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending Provider must determine whether a Member meets eligibility criteria for CHW services based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via the Adverse Childhood Events screening.
- Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
- Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital emergency department within the previous six months.
- One or more hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
- One or more stays at a detox facility within the previous year.
- Two or more missed medical appointments within the previous six months.
- Member expressed need for support in health system navigation or resource coordination services.

- Need for recommended preventive services, including updated immunizations, annual dental visit, and well childcare visits for children.

CHW violence prevention services are available to Members who meet any of the following circumstances as determined by a licensed practitioner:

- The Member has been violently injured as a result of community violence.
- The Member is at significant risk of experiencing violent injury as a result of community violence.
- The Member has experienced chronic exposure to community violence.

CHW violence prevention services are specific to community violence (e.g., gang violence). CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

In addition to Recommending Providers identifying a Member's need for CHW services, MCPs must also use data driven approaches to determine and understand priority populations eligible for CHW services, including but not limited to, using past and current Member utilization/encounters, data on health risks and clinical care gaps, frequent hospital admissions or ED visits, demographic and SDOH data, referrals from the community (including Provider referrals), and needs assessments, etc. MCPs should use these data sources to help identify Members who meet the eligibility criteria for CHW services and attempt outreach to qualifying Members and their Providers to encourage utilization of CHW services. MCPs should also encourage Providers to communicate with Members about the availability of CHW services. Additionally, MCPs should use SDOH Z-codes, results of SDOH screening questions, or other appropriate SDOH data sources to help with identification and assessment of priority populations as specified by DHCS.[11] MCPs are encouraged to ensure that priority populations match the unique needs of their local population in terms of lived experience, and target specific communities that are most vulnerable, including but not limited to populations experiencing health disparities as identified in DHCS' Health Disparities Report and communities residing in Quartiles one and two as defined by the California Healthy Places Index.[12]

[11] See APL 21-009, Collecting Social Determinants of Health Data. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[12] The Health Places Index is available at: https://www.healthyplacesindex.org/

Documentation Requirements
CHWs are required to document the dates and time/duration of services provided to Members. Documentation should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. For example, documentation might state, "Discussed the patient's challenges accessing healthy food and options to improve the situation for 15 minutes. Assisted with the Supplemental Nutrition Assistance Program application for 30 minutes. Referred patient to [XYZ] food pantry." Documentation must be accessible to the Supervising Provider upon their request. Documentation should be integrated into the Member's medical record and available for encounter data reporting.

Plan of Care
For Members who need multiple ongoing CHW services or continued CHW services after 12 units of services as defined in the Medi-Cal Provider Manual, a written care plan must be written by one or more individual licensed Providers, with the exception of services provided in the emergency department, which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.[13] The Provider ordering the plan of care does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services. CHWs may participate in the development of the plan of care and may take a lead role in drafting the plan of care if done in collaboration with the Member's care team and/or other Providers referenced in this section. The plan of care may not exceed a period of one year. The plan of care must:

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Include a list of other health care professionals providing treatment for the condition or barrier;
- Contain written objectives that specifically address the recipient's condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the plan's objectives.

A licensed Provider must review the Member's plan of care at least every six months from the effective date of the initial plan of care. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary. If there is a significant change in the recipient's condition,

[13] See CHW Preventive Services Medi-Cal Provider Manual.

Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

Covered CHW Services including Violence Prevention Services
CHW services can be provided as individual or group sessions. The services can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. There are no service location limits. Supervising Providers should refer to the Telehealth section in Part two of the Provider Manual for guidance regarding Telehealth.[14]
Services include:

- Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
- Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care. This includes connecting Members to community resources necessary to promote health; address barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
    - Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
    - Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
    - Help a Member enroll or maintain enrollment in government or other assistance programs that are related to improving their health, if such navigation services are provided pursuant to a plan of care.
- Screening and Assessment: Providing screening and assessment services that do not require a license, and assisting a Member with connecting to appropriate services to improve their health.
- Individual Support or Advocacy: Assisting a Member in preventing the onset or

[14] The Medi-Cal Provider Manual, Medicine: Telehealth, is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D5289F68-C42E-4FE8-B59F-FA44A06D2863/mednetele.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative of other covered benefits.

Services may be provided to a parent or legal guardian of a Member under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. A service for the direct benefit of the Member must be billed under the Member's Medi-Cal ID. If the parent or legal guardian of the Member is not enrolled in Medi-Cal, the Member must be present during the session.

CHWs may render street medicine. The Supervising Provider would bill MCPs for any appropriate and applicable services within the scope of the CHW benefit.

Covered CHW services do not include any service that requires a license.

Non-Covered CHW Services

- Clinical case management/care management that requires a license
- Child care
- Chore services, including shopping and cooking meals
- Companion services
- Employment services
- Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
- Delivery of medication, medical equipment, or medical supply
- Personal Care services/homemaker services
- Respite care
- Services that duplicate another covered Medi-Cal service already being provided to a Member
- Socialization
- Transporting Members
- Services provided to individuals not enrolled in Medi-Cal, except as noted above
- Services that require a license

Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services as these are covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. CHW services are distinct and separate from Peer Support Services.

Provider Enrollment
Network Providers, including those who will operate as Supervising Providers of CHW services, are required to enroll as Medi-Cal Providers, consistent with APL 22-013: Provider Credentialing/Re-credentialing and Screening/Enrollment, or any superseding APL, if there is a state-level enrollment pathway for them to do so.[15] [16]

CHWs are not required to enroll as Medi-Cal Providers and are therefore not subject to the requirements in APL 22-013, Provider Credentialing/Re-Credentialing and Screening/Enrollment. MCPs must develop and submit P&Ps for how they will ensure that Providers and Subcontractors that serve as CHW Supervising Providers are certifying that their CHWs have the appropriate training, qualifications, and supervision. MCPs must consider, at the minimum, the following CHW Supervising Provider characteristics in their P&Ps:

- MCP's ability to receive referrals from licensed practitioners for CHW benefits
- MCPs validating Supervising Providers are appropriately assessing CHWs have sufficient experience to provide services
- Ensuring Supervising Providers have the ability to submit claims or encounters to MCPs using standardized protocols
- MCPs ensuring Supervising Providers have business licensing that meet industry standards
- MCP's capability to comply with all reporting and oversight requirements
- MCP's monitoring processes for fraud, waste, and/or abuse of CHW services
- MCP's process for monitoring recent history of criminal activity of Supervising Providers
- MCP's process for monitoring history of liability claims against the Supervising Provider

Billing, Claims, and Payments
CHW services must be reimbursed through a CHW Supervising Provider in accordance with its Provider contract. Since CHW services are a preventive service, MCPs must not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the plan of care. MCPs must not establish unreasonable or arbitrary barriers for accessing coverage. Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual. MCPs and all Subcontractors and Network

[15] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[16] See Provider Enrollment Options at: https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx

Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM, which is inclusive of the services within the CHW benefit. Therefore, MCPs must ensure that Providers do not bill for CHW services and ECM for the same Member for the same time period.

Tribal clinics may bill MCPs for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Provider Manual.[17]

Pursuant to Welfare and Institutions Code (WIC) 14087.325(d)[18], MCPs are required to reimburse contracted Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that the MCP would make for the same scope of services if the services were furnished by another Provider type that is not an FQHC or RHC. This requirement applies to CHW services provided to eligible Medi-Cal Members consistent with the provisions outlined in this APL.

Access Requirements for CHW Services
As part of their Network composition, MCPs must ensure and monitor sufficient Provider Networks within their service areas, including for CHW services. MCPs should prioritize usage of CHW services for priority populations as mentioned above. DHCS strongly encourages MCPs to contract with existing CHW Networks serving Medi-Cal populations, especially those in local public health departments.

Specifically, DHCS encourages MCPs to ensure adequate CHW Networks to:

- Support integrated behavioral health models of care, including by increasing screening, brief intervention, and referral to treatment for substance use and mental health conditions for all age groups but especially children, youth, and pregnant/postpartum populations.
- Support improvements in access and utilization of children's preventive care services, especially focused on engagement of communities experiencing health disparities and leveraging DHCS-provided reports of Members who have not utilized services to guide the identification and engagement of target populations.

[17] See CHW Preventive Services Medi-Cal Provider Manual.
[18] WIC Section 14087.325. State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.

- Support improved birth outcomes by improving support of pregnant persons during the prenatal and postpartum period (through 12 months post-partum) in the clinical and home settings, and leveraging Comprehensive Perinatal Services Program perinatal health workers, where appropriate.

DHCS Monitoring
DHCS will monitor MCPs' implementation of CHW requirements through existing data reporting mechanisms, such as encounter data, grievances, and appeals. CHWs are not required to be entered in the 274 Network Provider File. As such, DHCS will obtain the number of CHWs within each Network, initially from the MCP through the CHW Integration Plan and included later through the PHM readiness submission as well as post-transition monitoring of CHW utilization.

MCPs must review their contractually required P&Ps to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, MCPs must submit their updated P&Ps to their Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include this APL title and the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Grievance and Appeal requirements[19], Contract requirements, and other DHCS guidance, including APLs and Policy Letters.[20] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

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[19] See APL 21-011, Grievance and Appeal Requirements, Notice and "Your Rights" Templates. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[20] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

Background on CalOptima Health's Community Health Worker Benefit

October 15, 2026

Benefit Background

Community Health Workers (CHWs) are trusted members of a community who have strong relationships with the individuals they serve and not only provide one-one-one care but also advocate on behalf of their communities. DHCS added CHW services as a Medi-Cal benefit starting July 1, 2022.

The intention of the CHW benefit, as outlined by DHCS guidelines, is to improve health outcomes by fostering patient engagement and addressing social determinants of health.
Specifically, the benefit aims to:

1. **Enhance Access to Care**: CHWs help individuals navigate the health care system, ensuring they receive timely and appropriate services.
2. **Provide Health Education**: They deliver culturally relevant information that empowers community members to manage their health effectively and make informed decisions.
3. **Support Chronic Disease Management**: CHWs assist patients with chronic conditions in maintaining their treatment plans and improving adherence to prescribed therapies.
4. **Address Social Determinants of Health**: By identifying and connecting individuals to community resources, CHWs address factors such as housing, food security, and transportation that impact health and well-being.
5. **Promote Health Equity**: The CHW initiative focuses on reducing health disparities among underserved populations by ensuring that care is accessible and tailored to the needs of diverse communities.

CalOptima Health Implementation Strategy

CalOptima Health took a phased approach to develop a sustainable and forward-thinking implementation strategy for the CHW benefit.

Phase 1- Co-Design Pilot: Identified and contracted with 5 community-based organizations that have robust CHW expertise and experience to inform and co-design the implementation of the CHW benefit. The pilot was a five-month process comprised of collaborative meetings with the CBOs that identified best practices for CHW services, training approaches/needs and internal and external workflows.

Phase 2- Expand Network with the CHW Academy: Developed and launched Notice of Funding Opportunity (NOFO) to support the selection of additional organizations to participate in a 6-month CHW Academy and be trained as CHW Supervising Providers. A total of 45 organizations applied for the NOFO, and 16 community-based organizations were chosen to participate in the CHW Academy alongside the 5 previously contracted CBOs.

CHW Academy

The CHW Academy was a 6-month training and onboarding program, comprised of 22 training modules, that reviewed the core components of the CHW benefit including DHCS requirements, CHW training and certification pathway options, billing, workforce sustainability and organizational infrastructure development. Participation in the academy was mandatory for organizations to be contracted to provide CHW services. Collectively all 21 organizations graduated from the CHW Academy and were contracted to provide CHW services as of December 2025.

CHW Provider Network

The 21 CHW contracted organizations represent a diverse group of agencies reflective of the CalOptima Heath membership. From Abrazar and Access California to Latino Health Access and Mom's OC, these agencies collectively strive to provide tailored health services that respect and reflect the varied cultural backgrounds of their clients. A key aspect of their work is fostering cultural competency, which involves understanding and integrating diverse cultural beliefs and practices into health interventions, as well as offering communication in multiple languages. Organizations such as the Korean American Center and the Cambodian Family further enhance this by specifically addressing the needs of Asian and Pacific Islander communities. Through the collaborative efforts of these organizations, including the Community Action Partnership of Orange County and the Multi-Ethnic Collaborative, a comprehensive framework is established that ensures marginalized populations receive equitable healthcare. By emphasizing culturally informed practices and community engagement, these agencies collectively enhance the delivery of CHW services to drive the overall well-being of Orange County's diverse communities.

CHW Contracted Providers

1. Abrazar, Inc.
2. Access California
3. Latino Health Access
4. MOMS OC
5. Western Youth Services
6. Sowing Seeds, Inc.
7. Community Health Initiative of Orange County
8. Community Action Partnership of Orange County
9. Delhi Center
10. First 5 Orange County
11. Korean American Center
12. Mariposa Center for Women and Families
13. Multi-Ethnic Collaborative of Community Agencies
14. Orange County Asian and Pacific Islander Community Alliance
15. The Cambodian Family
16. Vision y Compromiso
17. Vital Access Care Foundation
18. Mindful Living Center
19. Olive Crest
20. Shanti Orange County
21. St. Jeanne De Lestonnac Free Clinic

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

21. Authorize Amendments to the CalOptima Health Shared Risk Group Health Network Contracts Regarding the Shared Risk Pool Programs for the Medi-Cal, OneCare, and Covered California Programs

Contacts

Ladan Khamseh, Interim Chief Operating Officer, (714) 246-8866
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Authorize the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health Shared Risk Group Health Network Contracts, effective January 1, 2027, to ensure alignment with CalOptima Health Policies.

Background and Discussion

CalOptima Health provides information to the Shared Risk Group (SRG) Health Network providers related to the Shared Risk Pool (SRP) program in various ways. Currently, program information is outlined in the SRG Health Network's provider contracts and CalOptima Health finance policies, FF.1010: Shared Risk Pool, MA.3003: Medicare Shared Risk Pool, and CC.1800: Medical Group/Independent Physician Association (IPA) Compensation.

To eliminate redundancy and the risk of conflict between provider contract provisions and CalOptima Health policies, staff recommends revisions to the Shared Risk Group Health Network Contracts to refer directly to the applicable CalOptima Health finance policies corresponding to Medi-Cal, OneCare, or Covered California to clarify the details of the SRP programs. The CalOptima Health finance policies outline the administration process of each SRP program and provide a comprehensive summary of their components.

The SRG Health Network Contract amendments include the following changes:

- Removal of contract provisions and applicable attachments related to SRP payment provisions.
- Modification of language and/or additional reference to the applicable CalOptima Health finance policies related to SRP payment.

Staff seeks the CalOptima Health Board of Directors (Board) approval of the contract amendments to ensure alignment with and direct referral to the applicable CalOptima Health finance policies.

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Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

The above recommended action supports alignment with CalOptima Health policies and ensures cohesive communication with the health network providers regarding the SRP programs.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by the RecommendedAction
2. Medi-Cal Contract Amendment Template
3. OneCare Contract Amendment Template
4. Covered California Contract Amendment Template

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Attachment to the November 5, 2026, Board of Directors Meeting – Agenda Item #21

CONTRACTED / IMPACTED ENTITIES COVERED BY THE RECOMMENDED ACTION

Name	Address	City	State	Zip Code
AltaMed Healthcare Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Health Network	600 City Parkway West Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street Suite 107	Westminster	CA	92683
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Avenue	Cypress	CA	90630
Metropolitan IPA dba Prospect Medical Group, Inc.	1600 Corporate Center Drive	Monterey	CA	91754
Providence Medical Foundation	200 W. Center Street, Promenade Suite 300	Anaheim	CA	92805
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

The list above only includes information that staff found through a search of publicly available information, and Directors should not solely rely on this list in determining whether a conflict of interest exists. Only a Director is aware of all their relevant interests under California law, and the California Fair Political Practices Commission ("**FPPC**") concluded that individual Directors are responsible for their own conflict determinations and advice (or lack of advice) from another party is not a defense for a violation. As such, this list is simply one tool that Directors may use in determining whether a conflict of interest exists. If a Director has a question about whether a specific interest is disqualifying, the Director should seek legal counsel to assist in making that determination.

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AMENDMENT «Amendment_No» to
CONTRACT FOR HEALTH CARE SERVICES

This Amendment «Amendment_No» to the Contract for Health Care Services ("**Amendment**") is effective as of «Effective Date» ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and «Provider_Name» ("**Physician**"). CalOptima and Physician may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services originally effective «Base_Contract_Contract_Effective_Date», ("**Contract**"), under which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Parties desire to amend the Contract to delete provisions related to shared risk program and insert applicable policy references, as provided herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Section {1.86}, "Shared Risk Pool", shall be deleted in its entirety and replaced with the following new Section {1.86}, "Shared Risk Pool":

   {1.86} "Shared Risk Pool" means the risk sharing program, described in CalOptima Policy FF.1010, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and Physician.

2. Section {2.10}, MEDICAL LOSS RATIO, shall be deleted in its entirety and replaced with the following new Section {2.10}, MEDICAL LOSS RATIO:

   {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, outlined in CalOptima Policy FF.1010.

3. Section {13.13.2} shall be added to Section {13.13} PERFORMANCE MEASURE AND PAYMENTS TO PHYSICIAN as follows:

   {13.13.2} Physician shall participate in a shared risk program as defined in CalOptima Policy FF.1010.

4. Section {9.4.3}.3, *Shared Risk Pool Payments Upon Termination*, shall be deleted in its entirety and replaced with "Intentionally left blank".

5. Attachment {E-2}, Shared Risk Program, shall be deleted in its entirety and replaced with "Intentionally left blank".

6. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

DRAFT Pending Board Approval

7. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

8. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PHYSICIAN:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

DRAFT Pending Board Approval

AMENDMENT «Amendment_No» to
MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICES CONTRACT

This Amendment «Amendment_No» to the Medicare Advantage Physician Group Services Contract ("**Amendment**") is effective as of «Effective Date» ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency, dba CalOptima Health ("**CalOptima**"), and «Provider_Name» ("**Physician Group**"). CalOptima and Physician Group may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Physician Group have entered into a Medicare Advantage Physician Group Services Contract originally effective «Base_Contract_Contract_Effective_Date», ("**Contract**"), under which Physician Group has agreed to provide or arrange for the provision of Covered Services to Members.

B. The Parties desire to amend the Contract to delete provisions related to shared risk program and insert applicable policy references, as provided herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Section 6.7.3, *Shared Risk Pool Payments Upon Termination*, shall be deleted in its entirety and replaced with "Intentionally left blank".

2. Section 1.4, *Hospital Shared Risk Program Between CalOptima and Physician Group*, in «Attachment C», *Capitation Rates and Risk Sharing*, shall be deleted in its entirety and replaced with the following new Section 1.4. *Hospital Shared Risk Program Between CalOptima and Physician Group:*

   1.4 Hospital Shared Risk Program Between CalOptima and Physician Group. Physician Group shall participate in a shared risk program as defined in CalOptima Policy MA.3003.

3. Section 1.5, *Shared Risk Services – Definition*, in «Attachment C», *Capitation Rates and Risk Sharing*, shall be deleted in its entirety and replaced with "Intentionally left blank".

4. Section 1.6, *Shared Risk Budget and Costs*, in «Attachment C», *Capitation Rates and Risk Sharing*, shall be deleted in its entirety and replaced with "Intentionally left blank".

5. Section 1.7, *Copayments and Coordination of Benefits*, in «Attachment C», *Capitation Rates and Risk Sharing*, shall be deleted in its entirety and replaced with "Intentionally left blank".

6. Section 1.8, *Shared Risk Program Settlement*, in «Attachment C», *Capitation Rates and Risk Sharing*, shall be deleted in its entirety and replaced with "Intentionally left blank".

7. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

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8. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

9. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

DRAFT Pending Board Approval

AMENDMENT «Amendment_No» to
THE COVERED CALIFORNIA PHYSICIAN GROUP SERVICES CONTRACT (Shared Risk)

This Amendment «Amendment_No» to the Covered California Physician Group Services Contract (Shared Risk) ("**Amendment**") is effective as of «Effective Date» ("**Amendment Effective Date**"), by and between Orange County Health Authority, a public agency dba CalOptima Health, ("**CalOptima**"), and «Provider_Name» ("**Physician Group**"). CalOptima and Physician Group may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima and Physician Group entered into the Covered California Physician Group Services Contract (Shared Risk), originally «Base_Contract_Contract_Effective_Date» ("**Contract**"), under which Physician Group has agreed to provide or arrange for the provision of certain Covered Services to Covered California Members.

B. The Parties desire to amend the Contract to delete provisions related to shared risk program and insert applicable policy references, as provided herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Section {1.67}, "Shared Risk Pool", shall be deleted in its entirety and replaced with the following new Section {1.67}, "Shared Risk Pool":

   1.67 "**Shared Risk Pool**" means the risk-sharing program, described in CalOptima Policy CC.1800, under which the risk for the provision of Covered Services to Members is shared and allocated between CalOptima and Physician Group.

2. Section {6.5}, Medical Loss Ratio, shall be deleted in its entirety and replaced with the following new Section {6.5}, Medical Loss Ratio:

   6.5 Medical Loss Ratio. Physician Group 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, as outlined in CalOptima Policy CC.1800.

3. Section {9.1.1}, Capitation Payment, shall be deleted in its entirety and replaced with the following new Section {9.1.1}, Capitation Payment:

   9.1.1 CalOptima shall determine, in accordance with CalOptima Policy CC.1800, the Capitation Payment by multiplying the Capitation rate set forth in Attachment C-1 by the number of Members enrolled with Physician Group multiplied by the applicable relative risk score.

4. Section {9.1.4} shall be added to Section {9.1}, Payment, as follows:

   9.1.4 Physician Group's compensation for capitation, shared risk, and risk adjustment transfer payment adjustments shall be governed by CalOptima Policy CC.1800.

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5. Attachment {C-2}, Shared Risk Program, shall be deleted in its entirety and replaced with "Intentionally left blank".

6. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

7. If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern.

8. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PHYSICIAN GROUP:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

DRAFT Pending Board Approval

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

22. Adopt Resolution No. 26-1105-02 Approving Updated and New CalOptima Health Human Resources Policies

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Action

Adopt Resolution No. 26-1105-02 Approving Updated and New CalOptima Health Human Resources policies, effective November 5, 2026:

1. Updated CalOptima Health Policy GA.8018: Paid Time Off (PTO);
2. Updated CalOptima Health Policy GA.8042: Supplemental Compensation; and
3. New CalOptima Health Policy GA.8065: Paid Time Off (PTO) Donation Policy.

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 have included the list of two (2) updated policies and one (1) new policy for Board approval. A summary of changes for the updated policies follows.

Updated CalOptima Health Policy GA.8018: Paid Time Off (PTO). This policy provides managers and supervisors with appropriate guidelines for administering CalOptima Health's PTO benefit.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Minor grammar and formatting revisions throughout policy.	For clarity and accuracy.	For clarity and accuracy.
II.Policy.C (new)	Adds "For all other employees who are not eligible to accrue PTO, CalOptima Health will provide Paid Sick Leave in accordance with the California	Simplifies eligibility to receive Paid Sick Leave.	Provides clarity and transparency on Paid Sick Leave eligibility.

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Policy Section	Proposed Change	Rationale	Impact
	Healthy Workplaces, Healthy Families Act of 2014, utilizing the lump sum method."		
II.Policy.C (old)	Removes section, "C. California Healthy Workplaces, Healthy Families Act of 2014 ("Paid Sick Leave"), requires CalOptima Health to provide Paid Sick Leave to eligible employees. CalOptima Health already provides employees who are eligible to accrue PTO, as specified in Section III.B. above, a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the Paid Sick Leave law. For all other employees who are not eligible to accrue PTO as specified in Section II.B. above, such as As-Needed Employees, who work thirty (30) or more days within one (1) year from the start of their date of employment, the following provisions shall apply: 1. For eligible employees, CalOptima Health shall provide the full amount of forty (40) hours, or five (5) days, whichever is greater, of Paid Sick Leave at the commencement of employment and then at the beginning of each calendar year thereafter. As such, the employee will not accrue any additional Paid Sick Leave and will not carry over any unused sick leave hours to the	Removes section on Paid Sick Leave and moves it to the Supplemental Compensation Guidelines.	Provides clarity and transparency on Paid Sick Leave eligibility.

Policy Section	Proposed Change	Rationale	Impact
	following year. 2. Upon satisfying a ninety (90) day employment period, employees may use accrued sick leave for preventative care or diagnosis, and care or treatment of an existing health condition of the employee or the employee's family member. The Paid Sick Leave law defines a "family member" as a Child, Parent, Spouse, Registered Domestic Partner, grandparent, grandchild, sibling or Designated Person. Employees are limited to one Designated Person per twelve (12) month period and shall identify the Designated Person at the time Paid Sick Leave is requested. Eligible employees may also use accrued Paid Sick Leave for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. Paid sick leave will not be treated the same as PTO. Upon termination, resignation, retirement, or other separation from employment, CalOptima Health will not pay out employees for unused Paid Sick Leave accrued under the Paid Sick Leave law. In addition,		

Policy Section	Proposed Change	Rationale	Impact
	accrued Paid Sick Leave hours are not eligible for cash out. If an employee separates and is then rehired by CalOptima Health within one (1) year from the date of separation, the previously accrued and unused Paid Sick Leave hours (or equivalent PTO if rehired as a regular employee) will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to the Paid Sick Leave law's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their Paid Sick Leave hours immediately upon rehire, if eligible. Paid sick leave will not be retained or converted to PTO in the event a as-needed employee converts to a regular full-time or regular part-time employee."		
II.Policy.D	1. Adds to PTO Accrual section "eligible hours paid not to exceed 80 hours per pay period." 2. Adds "Additional exceptions are outlined in the PTO Guidelines." 3. Adds subsection noting "If a higher accrual rate is awarded during the onboarding process, as	Adds clarifying language that PTO accrual is based on eligible hours not to exceed 80 hours in a pay period. Adds clarifying language specifying how employees accrue PTO on an advanced tier progress based on years of seniority.	Provides accuracy and transparency to PTO eligibility and accrual.

Policy Section	Proposed Change	Rationale	Impact
	outlined in the PTO guidelines, the employee will remain at that accrual rate and not advance to the next tier until their seniority is equal to the next tier minimum seniority eligibility. The Chief Executive Officer may also approve additional modifications for position-based accrual levels as outlined in the PTO Guidelines." 4. Removes subsections "1. If an employee is rehired by CalOptima Health within ninety (90) calendar days from the date of separation, the employee's PTO accrual rate will include prior months of Continuous Service. For those employees who are rehired beyond ninety (90) calendar days after separation, the Chief Executive Officer will have the discretion to approve deviations of up to a maximum of eighty (80) accrued hours per year from the date of rehire. 2. On rare occasions and on a case-by-case basis, the Chief Executive Officer may approve deviations of up to a maximum of one hundred twenty (120) hours accrued per year from the accrual schedule below. 3. The CEO may authorize one-time PTO of up to a		

Policy Section	Proposed Change	Rationale	Impact
	maximum of eight (8) hours per employee per incident, in cases of local emergencies or unforeseen circumstances necessitating time off for the immediate protection, welfare and safety of the employee or CalOptima Health property."		
II.Policy.E	Revises effective date of the accrual schedule from "January 2, 2024" to "January 4, 2027."	Aligns accrual table changes with the pay period at the start of calendar year 2027.	Provides clarity and transparency on the effective date of the accrual schedule revisions.
II.Policy.E	1. Removes "thirty-six (36) months or one hundred (120) months" of service. 2. Replaces "required" with as "shown" pertaining to the PTO Accrual Schedule.	Removes redundant language on accruals and refers the reader to the accrual schedule table.	Provides clarity and accuracy.
II.Policy.E	Adds Table first column titled "Tiers" which includes tiers 1, 2, and 3.	New column identifying the accrual levels or Tiers to the PTO accrual table.	Provides clarity and accuracy.
II.Policy.E	Revises Table second column title from "Months of Continuous Service" to "Seniority."	Replaces phrase with glossary term.	Provides clarity and consistency.
II.Policy.E	Revises Table second column, from "7.0769" to "7.08", "8.6154" to "8.62" and "10.1538" to "10.16."	Rounds PTO accrual rate in hours from four decimal places to two decimal places for consistency within the Human Resources Information System (HRIS) and payroll configuration and calculation of PTO values.	Provides accuracy and transparency.
II.Policy.E	Adds Table third column, "Approximate Annual Accrual" and the numbers "184", "224," and "264."	Calculates the approximate annual PTO accrual for each of	Provides clarity and transparency.

Policy Section	Proposed Change	Rationale	Impact
		the corresponding PTO Tiers.	
II.Policy.E	1. Revises Table fifth Column title from "Annual Hourly Accrual" to "Maximum Accrual." 2. Revises Table fifth Column entries from "184" to "368", "224" to "448", and "264" to "528."	Demonstrates the maximum PTO accrual an employee can bank for each Tier.	Provides clarity and transparency.
II.Policy.I (old H)	Revises **"PTO for Leaves of Absence Pursuant to Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Other Leaves**: CalOptima Health is required to provides time off to eligible employees in accordance with applicable laws. Accrued PTO will be applied only to portions of FMLA or CFRA leave that are unpaid. When an employee is receiving wage-replacement benefits such as employer-paid disability benefits or workers' compensation temporary disability payments, use of PTO is voluntary. Employees may elect to use PTO solely to supplement income up to 100% of regular base wages. Use of accrued PTO during PDL is voluntary; employees who elect to use PTO must do so in accordance with CalOptima Health Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. The same voluntary PTO rule applies during any period in which the employee is receiving wage-replacement benefits, regardless	Provides clarity and accuracy to the use of PTO in the circumstance where an employee also receives other wage replacement pay from non-PTO sources.	Provides clarity and transparency.

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Policy Section	Proposed Change	Rationale	Impact
	of the type of protected leave. Accrued PTO will be automatically applied towards Paid Sick Leave for preventative care, or care of an existing health condition for the employee, or a family member as described in CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. Accrued PTO shall also be automatically used for time-off for Child-Related Activities, subject to the limitations under Labor Code, Section 230.8. Employees can elect to use accrued PTO to supplement disability benefits in accordance with CalOptima Health Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, and a total combined compensation shall not exceed 100% of the employee's regular base salary. Leave rights discussed herein may overlap" To, "**PTO Usage During Leaves of Absence**: Employees can elect to use accrued PTO to supplement disability benefits in accordance with CalOptima Health Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, and a total combined compensation shall not exceed 100% of the		

Policy Section	Proposed Change	Rationale	Impact
	employee's regular base salary. Leave rights discussed herein may overlap."		
II.Policy.L.4	Revises "at the time the PTO cash out is scheduled to be paid" with "during the second pay period in November each year."	Aligns policy to practice as PTO cash out occurs during the second pay period of November.	Provides transparency and clarity.
II.Policy.P (old)	Removes PTO Donation Program section and subsections from policy.	Language used to create new Policy GA.8065: Paid Time Off (PTO) Donation Policy.	Provides accuracy and clarity.
III.Procedure.A	Revises employee responsibility for PTO Request for Time Off Table from "If using PTO for illness or preventative treatment, enter time away from work request as PTO sick" to "PTO should be entered using the most appropriate PTO code based on the absence."	Instructs employees requesting PTO to select the PTO type appropriate to the nature of the absence in the payroll system.	Provides accuracy and clarity.
III.Procedure.C	Removes entire Section III.C "PTO Request for Donations (Recipient Employee)"	Language used to create new Policy GA.8065.	Provides accuracy and clarity.
III.Procedure.D	Removes entire Section III.D "PTO Request to Donate (Donor Employee)."	Language used to create new Policy GA.8065.	Provides accuracy and clarity.
IX.Glossary	Removes term and definition for "Good Standing" from Glossary.	Reference to Good Standing removed from policy.	Provides clarity and consistency.
IX.Glossary	Removes term and definition for "Paid Time Off (PTO) Exhaustion" from Glossary.	Reference to exhausting PTO removed from policy.	Provides clarity and consistency.
IX.Glossary	Removes term and definition of "Catastrophic Illness and Injury" from Glossary.	Reference to Catastrophic Illness and Injury removed from this policy and used in new Policy GA.8065.	Provides clarity and consistency.
IX.Glossary	Removes term and definition of "Prolonged Absence" from Glossary.	Reference to Prolonged Absence removed from policy.	Provides clarity and consistency.

Updated CalOptima Health Policy GA.8042: Supplemental Compensation. This policy provides general guidelines concerning the use of supplemental compensation above regular base pay to

compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

Policy Section	Proposed Change	Rationale	Impact
Throughout	Minor grammar and formatting revisions throughout policy.	For clarity and accuracy.	Provides clarity and accuracy.
II.Policy.A.3	Revises "Night Shift Premium/Shift Differential" to "Night Shift Differential Pay."	Renamed the supplemental pay to align with CalPERS naming convention.	Provides clarity and accuracy.
II.Policy.A.4	Revises "Active Certified Case Manager (CCM)/ Educational Incentive" to "Certified Case Manager Pay (CCM)/ Educational Incentive."	Renamed supplemental pay to align with certification name.	Provides clarity and accuracy.
II.Policy.E (old)	Removes Section II.E: "E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Health members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay. 1. Exempt Employees, who do not work in the Cultural & Linguistic Services Department (C&L) and who are not required as part of their regular job responsibilities to translate but are qualified to translate based on successfully passing the CalOptima Health Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during their own personal time based on the	Translation duties are contracted externally. Removes translation pay from policy.	Provides transparency and consistency.

Policy Section	Proposed Change	Rationale	Impact
	rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis. 2. There are two (2) key activities in providing translation services: a. Translation of materials from English into the desired language, or from another language into English; and b. Review and revision of the translation to ensure quality and consistency in usage of terms. 3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima Health will reimburse for services at the following rates: a. Translation – Thirty-five dollars ($35.00) per page; and b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page. 4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.”		
II.Policy.E (new)	Adds “Differential Pay” to section in two places.	Term added for clarity to distinguish between the night shift work schedule and the night shift supplemental compensation type.	Provides clarity and accuracy.
II.Policy.E	Revises Night Shift Differential Pay Table definition from “Night Shift – Seven (7) hours or more of	Night shift differential is an incentive for being	Provides clarity and accuracy.

Policy Section	Proposed Change	Rationale	Impact
	work between 3 p.m. and 8 a.m." to "Night Shift – Shift start time between 3 p.m. and 11 p.m."	scheduled to work in the evenings.	
II.Policy.F (new)	Revises "Call Back and On Call" to "On Call Accessible and On Call Working".	Clarifies that "Accessible" and "Working" are the two statuses of "On Call." Eliminates the confusion with "Call Back."	Provides clarity and accuracy.
II.Policy.F	1. Adds "Employees must ensure all On Call time is properly documented and approved." 2. Removes reference to "Call Back and" On Call.	It is the employee's responsibility to report On Call time on the timesheet and to the supervisor.	Provides clarity and consistency.
II.Policy.F	Removes Call Back from Table to align with Section II.F revisions including: 1. "Call Back – Employees must physically return to their worksite within one (1) hour when requested by a Supervisor, after their regular shift has ended and they have physically left the workplace. A Supervisor may assign employees other work until the minimum of four (4) hours has elapsed;" 2. "All Non-exempt employees;" and 3. "One and one half (1.5) times of regular base pay with a minimum of four (4) hours of pay. $3.00 per hour for being on call waiting. If a call is taken, employee is on call working and paid one and one half (1.5) times the regular base pay with a thirty (30) minute minimum call."	Removes Call Back pay from policy.	Provides clarity and consistency.
II.Policy.F	Revises and splits Table section "On Call" into two sections including:	Clarifies that "Accessible" and "Working" are the two statuses of "On	Provides accuracy and transparency.

Policy Section	Proposed Change	Rationale	Impact
	3. Revises to state "On Call Accessible - Employees scheduled for On Call Accessible must remain reachable outside their regularly scheduled work shifts and be available to report to work or address operational needs, as determined necessary by management. While On Call Accessible, employees are not actively engaged in work duties and are free to use their time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required;" "All Non-exempt employees;" and "$3.00 per hour." Adds "On Call Working – Employees who are On Call Accessible and are called to work either from home or at the work site will be considered in a status of "on call working;" "All Non-exempt employees;" and "Paid one and one half (1.5) times the regular base pay, with a thirty (30) minute on call guarantee."	Call." Provides the eligibility and pay rate.	
II.Policy.I (new)	Revises "Active Certified Case Manager (CCM) / Pay" to "Certified Case Manager Pay (CCM)".	To align with section II.Policy.A.4.	Provides clarity and consistency.
II.Policy.L (new)	1. Revises title from "Employee Incentive Program" to "Incentive Programs," 2. Adds "and subject to budget availability."	Adds budgetary control to employee incentives.	Provides transparency.
II.Policy.L	Moves and combines Section II.P with Section II.L. Section II.P	Combines and consolidates two	Provides clarity.

Policy Section	Proposed Change	Rationale	Impact
	read, "Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. An award of incentive compensation in one (1) year is not indicative or a guarantee of future awards of incentive compensation and does not alter the at-will nature of employment at CalOptima Health."	sections on employee incentives into a single section for organization.	
II.Policy.L.1	Adds "CalRecognition Award: At the discretion of the CEO, monetary recognition, not to exceed $2,000 per employee per award, may be paid to employees for demonstrating excellence and dignity in service to our members or for an extraordinary organization-wide contribution(s)."	Adds CalRecognition Awards to align policy to practice.	Provides consistency and transparency.
II.Policy.L.2	Moved original Section II.O Recruitment Incentive to Section II.L.2. 1. Revises title from "Recruitment Incentive" to "Sign-on Incentive." 2. Revises section, "At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approval" to "At the discretion of the CEO,	Reformatted to rename and list Sign-on Incentive, as a type of incentive program introduced in Section II.L. Clarifies incentive calculation for transparency.	Provides consistency and transparency.

Policy Section	Proposed Change	Rationale	Impact
	a sign-on incentive of up to a maximum of fifty thousand dollars ($50,000.00) may be offered to entice an individual to join CalOptima Health. Sign-on incentives require informing the Board of Directors after approval."		
II.Policy.L.3	1. Moves original Section II.N Retention Incentive to Section II.L.3. "N. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima Health may, at the discretion of the CEO, and on an exceptional basis, award a retention incentive." 2. Moves portion of original Section III.L to Section II.L.3, "The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors' approval."	Reformatted to list Retention Incentive as a type of employee incentive program introduced in Section II.L.	Provides consistency and clarity.
II.Policy.L.4	Adds subsection for Service Awards, "Service Award: Employee recognition to honor the completed years of public employment in the service to	Adds employee Service Awards to align policy to practice.	Provides consistency and transparency.

Policy Section	Proposed Change	Rationale	Impact
	CalOptima Health who have achieved significant career milestones. At the discretion of the CEO, employees may receive two thousand dollars ($2,000.00) after twenty (20) years of CalOptima Health service, plus five hundred dollars ($500.00) for every additional five (5) years of service."		
II.Policy.N (new)	Revises section from, "Lump Sum Bonus: Employees paid at or above the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for merit Bonus Pay delivered as a lump sum bonus in accordance with Section III.N. of this policy, provided that their performance meets the goals and objectives set forth by their managers." To, "Merit Lump Sum Bonus: Merit pay will typically be an increase to base pay; however, it may also be delivered as lump sum bonus for employees paid at or above the pay range maximum of their position. Merit Lump Bonus eligibility and calculation are described in Reference I: Compensation Administration Guidelines."	Aligns section to Policy GA.8057: Compensation Program Attachment Compensation Guidelines which is the source document for Merit Lump Sum.	Provides consistency and clarity.
II.Policy.S	Adds clarification, "and incumbent will return to their previous pay grade" when temporary upgrade pay (TUP) ends.	Provides clarity and direction on the job assignment when the temporary upgrade ends.	Provides consistency and clarity.
II.Policy.T	Adds new subsection, "T. Temporary Assignment Pay (TAP): At the discretion of the CEO, an employee assigned higher-level duties for a limited	TAP provides discretion for continuity during transitions and to support operational	Provides accuracy and transparency.

Policy Section	Proposed Change	Rationale	Impact
	duration may receive TAP either (1) as supplemental pay in addition to TUP when the TUP amount calculated under Section II.S does not provide compensation appropriate for the temporary assignment, or (2) as an alternative to TUP when the employee does not satisfy the eligibility requirements for TUP or when the CEO determines that an alternative compensation approach is appropriate. TAP will be based on the employee's qualifications, internal pay practices, and other relevant business considerations. When TAP is paid in addition to TUP, TAP will equal the difference between the employee's pay rate after application of TUP and the total temporary pay rate approved by the CEO. In all cases, the employee's total temporary pay rate may not exceed the maximum rate of the pay grade for the higher-level position or assignment. TAP will end when the temporary assignment or higher-level duties end. TAP is not considered Special Compensation for CalPERS reporting."	needs that are not met with TUP alone.	
III.Procedure D.	Removes "Translation Pay" section.	Aligns with revisions to II.Policy.E to sunset Translation Pay practice.	Provides consistency and transparency.
III.Procedure.D.1 (new)	Adds "Differential" as a defined Glossary term, to night shift section and removes "defined as seven (7) hours or more of work between 3pm and 8am."	Aligns with Revisions to II.Policy.E (new) on night shift schedules.	Provides consistency and transparency.
III.Procedure.D.2 (new)	Adds "work" alternative hours and night shift "differential" to the section.	Aligns with revisions to II.Policy.E (new).	Provides consistency and transparency.

Policy Section	Proposed Change	Rationale	Impact
III.Procedure.E	Revises "Call Back and On Call Pay" to "On Call Accessible and On Call Working" Pay.	Aligns with revisions to II.Policy.F regarding On Call status.	Provides consistency and transparency.
III.Procedure.H.	Revises "Active Certified Case Manager (CCM) Pay" to "Certified Case Manager Pay (CCM)."	Aligns with changes to II.Policy.I in regards to the name of this pay.	Provides consistency and transparency.
III.Procedure.K	Adds procedure for CalRecognition Award "As circumstances warrant, any leader who observed another employee demonstrating exceptional CARES values in the workplace may nominate that individual for this incentive. The nomination is sent by email with a supporting description of the achievement through the employee's department's reporting structure. The area Chief may provide the final nomination to the CEO. The CEO makes the final approval if any and determines the incentive amount. If approved by the CEO, the incentive is processed into payroll, and the certificate is prepared by Human Resources for the issuing department leader."	Provides procedure and approval path for employee incentive CalRecognition. Aligns practice to policy.	Provides consistency and transparency.
III.Procedure.M	1. Revises "Recruitment Incentive" to "Sign-on Incentive." 2. Removes "Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive level positions and require informing the Board of Directors after approval."	Aligns to revisions made in II.Policy.L.2 regarding Sign-on Incentive.	Provides consistency and transparency.
III.Procedure.N	Adds "Service Award: Employees earn years of service credit toward this award through each complete year of employment with CalOptima Health. Service years	Describes how years of service are counted for purposes of Service Awards.	Provides consistency and transparency.

Policy Section	Proposed Change	Rationale	Impact
	do not have to be consecutive for purposes of Service Award. At the discretion of the CEO, Service Awards are issued annually to eligible employees to celebrate their long-term commitment to the agency and our members."	Aligns policy to practice.	
III.Procedure.O	Revises "Annual Performance" to "Merit"	Aligns with revision of term in policy and procedure sections.	Provides consistency and clarity.
III.Procedure.T	Adds section, "Temporary Assignment Pay (TAP): As circumstances warrant, the CEO may approve TAP, including whether it will be paid in addition to TUP or as an alternative to TUP and the approved total temporary pay rate. Human Resources will determine and document eligibility, calculate the TAP amount, confirm that the employee's total temporary pay rate does not exceed the applicable pay-grade maximum, and provide the approved amounts and effective dates to Payroll. Human Resources will review any change in the assignment that may affect eligibility or the approved amount. TAP will be discontinued when the approved temporary assignment or higher-level duties end."	Aligns with the addition of II.Policy.S in the policy. Describes approval, review, and implementation steps.	Provides consistency and clarity.
III.Procedure.U	1. Revises "Premium" to "Differential." 2. Removes "Call Back or" and "Active." 3. Revises "(CCM) Pay" to "Pay (CCM)."	Aligns with revision of term in policy and procedure sections.	Provides consistency and clarity.
III.Procedure.W	Removes "Active" and adds "(CCM)."	Aligns with revision of term in policy and procedure sections.	Provides consistency and clarity.

Policy Section	Proposed Change	Rationale	Impact
IX. Glossary	Adds term Night Shift and definition "Regularly scheduled shifts with start time between 3 p.m. and 11 p.m."	Aligns with new term in policy and procedure sections.	Provides consistency and clarity.

New CalOptima Health Policy GA.8065: Paid Time Off (PTO) Donation Policy. This policy establishes the CalOptima Health PTO donation program, which allows eligible employees to voluntarily donate a portion of their accrued PTO to another employee who is experiencing a qualifying catastrophic illness or injury, or who is caring for a qualifying family member with a catastrophic illness or injury. The primary objective of this program is to provide temporary financial support during an approved medical absence when the recipient employee has exhausted all available employer paid leave.

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 2026-2027 Operating Budget.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 26-1105-02 Approving Updated and New CalOptima Health Human Resources Policies
2. CalOptima Health Policy GA.8018: GA.8018 Paid Time Off (PTO)
3. CalOptima Health Policy GA.8042: Supplemental Compensation
4. CalOptima Health Policy GA.8065: Paid Time Off (PTO) Donation Policy

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RESOLUTION NO. 26-1105-02

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

APPROVE UPDATED AND NEW 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 and new 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 and new CalOptima Health Human Resources policies:

1. Updated CalOptima Health Policy GA.8018: Paid Time Off (PTO);
2. Updated CalOptima Health Policy GA.8042: Supplemental Compensation; and
3. New CalOptima Health Policy GA.8065: Paid Time Off (PTO) Donation Policy.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 5th day of November 2026.

AYES:

NOES:

ABSENT:

ABSTAIN:

_____

Title: Chair, Board of Directors

Printed Name and Title: Vicente Sarmiento, Chair, CalOptima Health Board of Directors

Attest:

_____

Tina Knapp, MMC
Clerk of the Board

Policy:	GA.8018
Title:	**Paid Time Off (PTO)**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/27/2011
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy provides managers and supervisors with appropriate guidelines to administer CalOptima Health's Paid Time Off (PTO) benefit.

II. POLICY

A. CalOptima Health provides PTO as~~,~~ a work-life balance benefit~~,~~ to all eligible employees to allow~~enable~~ them to take time off from work for activities such as rest, recreation, recovery, and ~~from injury and illness or~~ other personal activities of various kinds. CalOptima Health believes this time is valuable for employees in order to enhance productivity and make the work experience more personally satisfying. CalOptima Health's PTO program is not intended to and should not be considered to be a salary continuation program. CalOptima Health provides employees with additional hours of PTO as months of service are accumulated.

B. Full-Time, Part-Time, and Limited Term Employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. An eligible employee may use accrued PTO hours to take time off from work for any reason. CalOptima Health encourages employees to maintain work-life balance by utilizing PTO benefits for rest and recreation throughout the year. Employees who satisfy eligibility requirements set out in CalOptima Health's respective policies and applicable federal and state laws may be granted other types of leaves of absence. ~~CalOptima Health may require employees to use accrued PTO only for portions of a leave that are actually unpaid. PTO will not be required during any period when the employee is receiving wage replacement benefits, including employer-paid disability benefits or workers' compensation temporary disability payments.~~

~~Unless otherwise prohibited by law, such leaves may require employees to use accrued PTO before transitioning to unpaid leave.~~

~~B.~~C. For all other employees who are not eligible to accrue PTO, CalOptima Health will provide Paid Sick Leave in accordance with the California Healthy Workplaces, Healthy Families Act of 2014, utilizing the lump sum method.

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C. California Healthy Workplaces, Healthy Families Act of 2014 ("Paid Sick Leave"), requires CalOptima Health to provide Paid Sick Leave to eligible employees. CalOptima Health already provides employees who are eligible to accrue PTO, as specified in Section III.B. above, a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the Paid Sick Leave law. For all other employees who are not eligible to accrue PTO as specified in Section II.B. above, such as As-Needed Employees, who work thirty (30) or more days within one (1) year from the start of their date of employment, the following provisions shall apply:

1. For eligible employees, CalOptima Health shall provide the full amount of forty (40) hours, provide the full amount of forty (40) hours, or five five (55) days, whichever is greater, of Paid Sick Leave at the commencement of employment and then at the beginning of each calendar year thereafter. As such, the employee will not accrue any additional Paid Sick Leave and will not carry over any unused sick leave hours to the following year.As such, the employee will not accrue any additional Paid Sick Leave and will not carry over any unused sick leave hours to the following year.

2. Upon satisfying a ninety (90) day employment period, employees may use accrued sick leave for preventative care or diagnosis, and care or treatment of an existing health condition of the employee or the employee's family member. The Paid Sick Leave law defines a "family member" as a Child, Parent, Spouse, Registered Domestic Partner, grandparent, grandchild, sibling or Designated Person. Employees are limited to one Designated Person per twelve (12) month period and shall identify the Designated Person at the time Paid Sick Leave is requested. Eligible employees may also use accrued Paid Sick Leave for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking.

Paid sick leave will not be treated the same as PTO. Upon termination, resignation, retirement, or other separation from employment, CalOptima Health will not pay out employees for unused Paid Sick Leave accrued under the Paid Sick Leave law. In addition, accrued Paid Sick Leave hours are not eligible for cash out. If an employee separates and is then rehired by CalOptima Health within one (1) year from the date of separation, the previously accrued and unused Paid Sick Leave hours (or equivalent PTO balance if rehired as a regular employee) will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to the Paid Sick Leave law's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their Paid Sick Leave hours immediately upon rehire, if eligible.

3. Paid sick leave will not be retained or converted to PTO in the event a as-needed employee converts to a regular full-time or regular part-time employee.

D. **PTO Accrual:** An eligible employee begins accruing PTO on their hire date, based on hours paid each pay period (eligible hours paid not to exceed 80 hours per pay period excluding overtime for Non-Exempt Employees), and months of Continuous Service in accordance with the accrual schedule provided below. Additional exceptions are outlined in the PTO Gguidelines., with the following exceptions:

E.

E. If an employee is rehired by CalOptima Health within ninety (90) calendar days from the date of separation, the employee's PTO accrual rate will be based on seniority with CalOptima Health. For new employees, the seniority date will be the start date. For rehired employees, the seniority date is recalculated by adding days not employed to the original hire date. include prior months of Continuous Service. For those employees who are rehired beyond ninety (90) calendar days after

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separation, the Chief Executive Officer will have the discretion to approve deviations of up to a maximum of eighty (80) accrued hours per year from the date of rehire.

F.

On rare occasions and on a case-by-case basis, the Chief Executive Officer may approve deviations modifications of the up to a maximum accrual level based on seniority of the PTO charts below. The modified accrual level may not exceed the accrual rate of the highest PTO accrual tier. of one hundred twenty (120)40 hours hours accrued per year from the accrual schedule below. If a higher accrual rate is awarded during the onboarding process, the employee will remain at that accrual rate until they reach the seniority to progress to the next accrual rate tier. For example, a newly hired employee who is granted an accrual modification to accrue at tier level 2 will stay at the tier 2 level and not advance to tier three until seniority is equal to the minimum tier 3 level.

D.

1. If a higher accrual rate is awarded during the onboarding process, as outlined in the PTO guidelines, the employee will remain at that accrual rate and not advance to the next tier until their seniority is equal to the next tiers minimum seniority eligibility. The Chief Executive Officer may also approve additional modifications for position-based accrual levels as outlined in the PTO gGuidelines.

2.1.

3. The CEO may authorize one-time PTO of up to a maximum of eight (8) hours per employee per incident, in cases of local emergencies or unforeseen circumstances necessitating time off for the immediate protection, welfare and safety of the employee or CalOptima Health property.

G.E. **Annual Paid Time Off Benefits Accrual Schedule**

(Effective the Pay Period that Includes January 42, 20274)

In the accrual tables below, the total hours accrued areis based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period. The increase in PTO accrual will take effect at the end of the pay period following completion of thirty-six (36) months or one hundred twenty (120) months of service as shown required in the table below.

Tier	Months of Continuous Seniority Service	Hours of PTO Accrued (Biweekly pay period)	Approximate Annual Accrual	Maximum AccrualAnnual Hourly Accrual
1	Up to 36 Months	7.076908	184	184368
2	36+ Months to 120 Months	8.615462	224	224448
3	120+ Months to 180 Months	10.153816	264	264528

Note: 36 Months = 3 years; 120 months = 10 years 180 = 15 years

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~~H.~~F. **Maximum Accrual:** Limits are imposed on the amount of PTO that can be maintained in an employee's PTO account. If available, PTO is not used by the end of the benefit year [benefit year is the twelve (12) month period from hire date], employees may carry unused time off into subsequent years, up to the maximum accrual amount specified herein. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's Annual Accrual (see chart above). If an employee reaches their maximum PTO accrual amount, the employee will stop accruing PTO.

~~I.~~G. **PTO Accrual during Leaves of Absence:** PTO does not accrue when absent from work in connection with an approved or unapproved unpaid Leave of Absence, including, but not limited to, workers' compensation leave, or short/long term disability. PTO accruals ~~recommence~~ resume when the employee returns to work from an unpaid Leave of Absence.

~~J.~~H. **PTO Scheduling**: Scheduling of PTO is to be done in a manner compatible with CalOptima Health's operational requirements. In order to minimize the impact of an employee's absence, planned time off should be submitted by an employee to their immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO. Supervisors have authority to approve or deny PTO requests based on business needs, and CalOptima Health will not be responsible for any expenses incurred by an employee if the request for PTO is not approved. Each department may have special scheduling requirements and procedures for requesting PTO; therefore, employees should check with their immediate supervisor in advance, except for purposes of sick leave. In rare cases, an Executive may authorize the rescission of approved PTO to address urgent, emergent, or emergency situations. Notification to the employee will be made as soon as the need is known.

~~K.~~I. **~~PTO Usage During Leaves of Absence: PTO for Leaves of Absence Pursuant to Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Other Leaves~~**: ~~CalOptima Health is required to provides time off to eligible employees in accordance with applicable laws. Accrued PTO will be applied only to portions of FMLA or CFRA leave that are unpaid. When an employee is receiving wage-replacement benefits such as employer-paid disability benefits or workers' compensation temporary disability payments, use of PTO is voluntary. Employees may elect to use PTO solely to supplement income up to 100% of regular base wages. automatically be used to pay employees for any period of time taken off under the FMLA, and/or the CFRA in accordance with CalOptima Health Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. Use of PTO for any period of time taken off under PDL is at the discretion of the employee. Use of accrued PTO during PDL is voluntary; employees who elect to use PTO must do so in accordance with CalOptima Health Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. The same voluntary PTO rule applies during any period in which the employee is receiving wage-replacement benefits, regardless of the type of protected leave. Accrued PTO will be automatically used applied towards Paid Sick Leave for preventative care, or care of an existing health condition for the employee, or a family member as described in CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. Accrued PTO shall also be automatically used for time off for Child-Related Activities, subject to the limitations under Labor Code, Section 230.8. At the employee's discretion, PTO may also be used to supplement an employee's income, up to one hundred percent (100%) if an employee is receiving disability benefits during an approved Leave of Absence.~~ Employees are required to use available accrued PTO to cover any period of an approved leave of absence that would otherwise be unpaid, subject to applicable federal and state laws. When an employee is receiving disability benefits, the

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~~E~~employee~~s~~ may~~can~~ elect to use accrued PTO to supplement their disability benefit~~s~~ in accordance with CalOptima Health's Leave of Absence policies. ~~Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, and a total~~The combined compensation received from disability benefits and PTO shall not exceed 100% of the employee's regular base salary. ~~Leave rights discussed herein may overlap.~~

~~L.~~J. **Unscheduled PTO**: Regardless of the reason for an unscheduled absence, an employee shall notify their immediate supervisor in accordance with CalOptima Health Policy GA.8059: Attendance and Timekeeping. Notification of an unscheduled absence does not make the absence authorized. An employee shall enter the PTO request into the timekeeping system as soon as reasonably possible, and the employee's PTO account will be deducted accordingly. If an employee is absent for six (6) consecutive days or more on personal and unprotected sick time, a doctor's note is required on the first day back. Excessive use of unscheduled PTO may result in discipline, up to and including termination.

~~M.~~K. **Holidays Occurring During PTO**: If an observed CalOptima Health holiday occurs during an employee's scheduled PTO, the employee's PTO account will not be deducted for that holiday day, unless the full-time Non-Exempt Employee is on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule. In this case, the employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor.

L. **Maximum Annual Cash Out**: An election period will be held each year at about the same time as CalOptima Health's annual open enrollment period. During this time, each employee may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee ~~will~~ may be eligible to accrue at the time of cash out in the next calendar year. Once the election period closes, but in no event after December 31 of the year prior to payment of the cash out, the request for PTO cash out cannot be revoked. Requests for cash out will be paid out once per calendar year as determined by the Human Resources Department, provided that all of the following criteria are met:

1. ~~(1) t~~The employee made the election during the applicable open enrollment period; and

~~, (2) t~~The employee has actually accrued the requested ~~amount~~number of hours in the same year and by the time the cash out is made; ~~,~~ and

2. ~~For example, if an employee reaches maximum accrual for a portion of the year, the number of hours eligible for PTO Annual Cash out will be reduced to the hours actually accrued at time of cash out.~~

3. ~~(3) a~~A minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out.

   a. ~~-~~If the employee's election to cash out is for more hours than are eligible, the cash out will be limited to the number of eligible PTO hours at the time the cash out is made.

~~-~~Cashed out PTO will be paid at the employee's current hourly rate ~~at the time the PTO cash out is scheduled to be paid~~during the second pay period in November each year, subject to all applicable taxes and deductions.

4. ~~1.~~

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~~N.~~M. **Cash Out for Financial Hardship:** If during the year an employee experiences a personal financial hardship, the employee can cash out their accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need and there must be no other resources readily available to handle that financial need. Financial hardships shall be limited to the following reasons:

1. Expenses for, or necessary, to obtain non-reimbursed medical care for employee or immediate family members;

2. Payment for the purchase of a primary residence;

3. Payment of tuition, related education fees, and room and board expenses for postsecondary education for the employee, or the employee's spouse (or Registered Domestic Partner), a Child, or dependents;

4. Payments necessary to prevent the employee from eviction or foreclosure;

5. Expenses for the repair of damage to an employee's primary residence for damages from natural disasters; or

6. Expenses for the burial, funeral, or memorial for an employee's deceased Parent, spouse (or Registered Domestic Partner), Child, or dependents.

~~O.~~N. **PTO Pay/Flex Pay on Termination**: Employees are expected to give at least two (2) weeks' written notice prior to resigning from their employment. Notice of resignation is expected to be a "working" notice to allow an opportunity for productive work time to complete projects, or train whoever will be assuming the employee's responsibilities. For that reason, employees should avoid using accrued PTO during the two (2) week period preceding their last scheduled day of work and/or coordinate the use of PTO hours to provide at least two (2) "working" weeks. In no event shall CalOptima Health permit an employee to use their accrued PTO beyond the last day worked by an employee, unless the employee was on an approved Leave of Absence, or unless otherwise required by law. Upon termination of employment, the employee is paid all accrued unused PTO and Flex Holiday time at the employee's base rate of pay, subject to all applicable taxes, at the time of the termination. According to California Labor Code, Section 220(b), as a public agency, CalOptima Health is not required to pay wages immediately upon termination. CalOptima Health will pay the employee on the next regularly scheduled pay day.

~~*** END POLICY HERE – Donation moved to separate policy ***~~

~~P. **PTO Donation Program**: At the discretion of the Human Resources Department, a PTO Donation Program may be implemented. Employees may donate accrued PTO hours to assist another CalOptima Health employee ("recipient employee") when a recipient employee, or their family member, qualifies as having a Catastrophic Illness or Injury. Donations are completely voluntary, and donors will remain anonymous to the recipient employee. The PTO Donation Program allows eligible employees to voluntarily donate a portion of their accrued PTO to another CalOptima Health employee ("recipient employee") who is experiencing a qualifying catastrophic illness or injury, or who is caring for a qualifying family member with a catastrophic illness or injury. The program is intended to provide temporary financial support during approved periods of unpaid leave~~

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when an employee has exhausted available PTO and is not eligible for wage replacement benefits or has exhausted such benefits and remains unable to work. Participation in the PTO Donation Program is entirely voluntary on the part of CalOptima Health. The program may be amended or terminated at any time at the sole discretion of the Human Resources Department.

1. To be eligible to receive PTO donations, a recipient employee must meet all the following criteria:

a. Have a medically verified Catastrophic Illness or Injury, or be caring for a qualifying family member with such a condition.which shall mean a medically verified, life threatening or debilitating illness, injury or condition which is monumental, unusual, unexpected, immediate in nature or have a family member with such illness, injury or condition, which requires the employee take a Prolonged Absence which will result in a substantial loss of income to the employee because the employee will have reached PTO Exhaustion apart from the PTO Donation Program. Family members referenced above shall include an employee's spouse or Registered Domestic Partner, Child, or Parent;

b. Have worked for CalOptima Health for at least ninety (90) days and be eligible to accrue PTO hours under this Policy;

c. Be in Good Standing (no written warnings or corrective action plans within the last six (6) months, and the most recent performance evaluation shows the employee is meeting the performance standards);

Reached exhaustion of all paid leave available, including, but not limited to, accrued PTO, short-term or long-term disability benefits and other applicable paid leave balances. PTO Exhaustion;

1. Accrued PTO will be applied in increments of no less than one quarter hour (fifteen (15) minutes) when less than a full day of PTO is available. When accrued PTO balance is less than one quarter hour (fifteen (15) minutes), PTO is considered to be exhausted with the exception of PTO pay on termination.

d. Be in active status

Completed Submitted a completed written request and authorization form, including the required medical certificationdocumentation and the recipient employee's written authorization permitting CalOptima Health to issue an all-staff email announcing the opportunity for employees to donate PTO on the recipient employee's behalf.to be approved by the Human Resources Department;

Upon approval of a PTO donation request, Human Resources will issue an all-staff announcement providing employees with the opportunity to donate accrued PTO to the designated recipient.

The announcement will remain active for a period not to exceed four (4) weeks or until the maximum allowable amount of donations has been received, whichever occurs first.

By submitting a request, the employee agrees to indemnify, defend, and hold CalOptima Health harmless against any and all claims, liabilities, or actions arising out of or related to the authorized disclosure of such information.

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g. Have the scheduled time off or Leave of Absence (LOA) approved by CalOptima Health in accordance with CalOptima Health's LOA and Personal LOA Policies; andHave an approved Leave of Absence (LOA) or scheduled time off in accordance with CalOptima Health's LOA and Personal LOA Policies and remain in compliance with all applicable leave requirements

- Be actively employed at the time of the request and not have Have not resigned or been terminated from employment prior to or during the employee's time off or Leave of Absenceleave period.

    0. Eligibility for donated PTO will end immediately upon separation of employment.

- Permitted Use of Donated PTO: Donated PTO may only be used for time that would otherwise be unpaid and may not be used to supplement or extend other forms of paid leave or wage replacement benefits. Use of donated PTO is limited to the following circumstances:

- Short-Term Disability Waiting Period: To cover the approved waiting period before short-term disability benefits begin; or

- Ineligibility for Wage Replacement Benefits: When the employee does not qualify for short-term disability or other wage replacement benefits; or

- Exhaustion of Wage Replacement Benefits: When the employee has exhausted available disability or other wage replacement benefits and remains unable to work due to a qualifying condition; or

- Care for a Qualifying Family Member: When the employee is on approved unpaid leave to care for a qualifying family member with a catastrophic illness or injury and has exhausted all available PTO

- Maximum Allowable Donated PTO Hours: Donated PTO is subject to the following limits:

- Waiting Period Limit: When used to cover a short-term disability waiting period, donated PTO is limited to the number of work hours in the applicable waiting period (e.g., up to 80 hours for a full-time employee)

- Rolling 12-Month Maximum: For non-waiting period circumstances, the total amount of donated PTO an employee may receive is limited to a maximum of two-hundred and forty (240) hours within a rolling twelve (12) month period, measured backward from the date donated PTO is first applied. All donated PTO received, regardless of the number of qualifying events, leave requests, or return-to-work periods, will count toward this rolling 12-month maximum.

2. To donate PTO under this program, a donor Employee must meet all the following criteria:

    a. Donate and surrender a minimum of one (1) hour, in whole-hour increments.in increments of one (1) hour.

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b. Maintain a minimum balance of one hundred (100) accrued PTO hours in the donor employee's PTO account after the donation is processed. Requests that would reduce the donor employee's PTO balance below the minimum threshold will not be approved.

Submit a form authorizing the donation and acknowledging that the following:

The donation is voluntary, and;

The transfer of PTO hours has been authorized, and;

1. That donated PTO hours are irrevocable once the donation has been processed and transferred to the recipient employee. The donor employee may not rescind, cancel, or recover the donated hours for any reason.the donated PTO hours have been surrendered to CalOptima Health for the benefit of another employee and is no longer a benefit to the donor employee.

3. PTO donation processing.

a. Donated PTO hours will be converted based on the donor's and the recipient employee's respective hourly pay rates.

1. Donated PTO hours are first converted into a dollar value using the donor employee's regular hourly rate of pay at the time of conversion. The resulting dollar value is then converted into PTO hours for the recipient employee using the recipient employee's regular hourly rate of pay.

a. Example: If a donor employee earning $25.00 per hour donates eight (8) hours of PTO, the total value of the donation is $200.00. If the recipient employee earns $20.00 per hour, the recipient will receive ten (10) hours of PTO ($200.00 / $20.00 = 10 hours).

2. The calculated PTO hours will be credited to the recipient employee's PTO bank and made available for use during the applicable payroll period(s) in which the employee is approved for catastrophic leave.pay rate. PTO hours donated shall be converted to dollars at the hourly rate of the donor. The dollars shall then be converted to PTO at the hourly rate of the recipient of the donation. For example, if a donor employee is regularly paid $25.00 per hour and donates eight (8) hours of PTO to a recipient employee who is regularly paid $20.00 per hour, the recipient employee will receive ten (10) hours of paid leave, paid at $20.00 per hour (8 hours x $25.00 = $200 value, and $200 value/$20.00 per hour = 10 hours). The appropriate hours of PTO will then be added to the recipient's PTO account for use during the payroll period(s) in with the employee is in need of catastrophic leave. The recipient employee is responsible for the tax burden of the donation.

b. Donated PTO is considered taxable income to the recipient employee. The recipient employee is responsible for any taxes associated with the donated PTO received. Applicable taxes will be withheld in accordance with standard payroll practices.

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- PTO donation processing. Each donation request will be processed in the order in which completed and approved donation forms are received.

    - Recipient employees may receive donations in excess of need for a specific pay period. Donations will be processed and transferred to recipient employee when the hours are needed.

        - Donor employee donations will be processed in the order received based on recipient need.

        - If any approved donation forms remain unprocessed at the conclusion of the recipient employee's approved catastrophic leave period, or once the maximum allowable donated PTO has been reached:

            - The remaining unprocessed donation requests will be voided; and

            - The corresponding PTO hours will remain in the donor employee's PTO balance (i.e., no deduction will occur)

    - Donated PTO hours will be applied beginning with the earliest date within the pay period in which the donor's signed donation form was received by Human Resources. , in which case the first donor employee's PTO would be converted and applied to the recipient employee's PTO bank for the first payroll period in which the donations are being utilized. The second donor employee's PTO may then be used and applied to the recipient employee's PTO bank for the same or next payroll period.

    - Subsequent donations will be applied to the same or following payroll period(s), as needed, until the recipient's is no longer eligible or Maximum Allowable Donated PTO Hours limit is reached.similarly processed. If any forms authorizing the donation of hours remain at the end of the recipient employee's catastrophic leave, the unprocessed forms shall be returned to the donor.

- . All donations are subject to review and approval by Human Resources to ensure compliance with this policy.

5. Disability or workers' compensation. If a recipient employee is receiving short term or long term disability or workers' compensation benefits, the recipient employee may coordinate the donated PTO hours with these benefits to supplement the recipient employee's income to receive one hundred percent (100%) of the employee's salary. For instance, if the recipient employee is receiving sixty percent (60%) of their income from short term disability, CalOptima Health will allow the recipient employee to use the donated PTO hours to supplement the forty percent (40%) difference in compensation, bringing the recipient employee's total monthly income to one hundred percent (100%) of their earnings.

6. The recipient employee must submit an application and all necessary documentation to the Human Resources Department to be a recipient of the donated PTO and must give CalOptima

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~~Health permission to issue an all-staff email announcing the opportunity to donate PTO. The email will identify the recipient employee and any other information expressly authorized by the recipient employee. From the date of sending the announcement, there will be a four (4) week period for donor employees to submit their donations.~~

~~7. In submitting an application, the recipient employee will be required to indemnify, defend, and hold CalOptima Health harmless from any claims, liability, or actions concerning the disclosure of health information authorized by the recipient employee.~~

~~8. This PTO Donation program is completely voluntary on the part of CalOptima Health and may be amended or terminated by the Human Resources Department at any time at its sole discretion.~~

III. ~~-~~PROCEDURE

A. PTO Request for Time Off:

Responsible Party	Action
Employee	• Request PTO at least two (2) weeks in advance, where possible, using CalOptima Health's time-keeping system. If the need for time off is foreseeable, ~~employee~~employees must provide reasonable advance notice. If not, the employee must provide notice as soon as practicable. PTO should be entered using the most appropriate PTO code based on the absence.~~(If using PTO for illness or preventative treatment, enter time away from work request as PTO Sick).~~
Supervisor	• Review all requests and approve, or deny, the request.

B. PTO Request to Cash Out:

Responsible Party	Action
Employee	• Request PTO cash out for the following year during the designated election period
Payroll	• Review all requests and approve or deny the request.

~~C. PTO Request for Donations (Recipient Employee):~~

~~Responsible Party~~	~~Action~~
~~**Recipient Employee**~~	~~• Request a Leave of Absence.~~ ~~• Submit a completed Complete a written request and authorization form including supporting medical documentation to be submitted to the Human Resources Department for approval, if eligible.~~
~~**Human Resources Department**~~	~~• Receive request and authorization form from recipient employee and review for completeness and eligibility.~~ ~~• Within ten (10) days of receipt of all necessary material provide notice to recipient employee whether or not Human Resources approves or rejects the employee's request. Where approved, send out email request to all CalOptima Health employees consistent with permissible information provided by the recipient employee.~~

~~D. PTO Request to Donate (Donor Employee):~~

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~~Responsible Party~~	~~Action~~
~~Donor Employee~~	• ~~Submit a form, authorizing the donation, and designating the number of hours surrendered to be transferred to to CalOptima Health for the benefit of a recipient employee, and acknowledging .~~ • ~~Sign an acknowledgement that the donated PTO hours has are irrevocable once the donation has been processed and transferred to the recipient employee. been surrendered to CalOptima Health for the benefit of a recipient employee and is no longer a benefit to the donor employee.~~
~~Human Resources Department~~	• ~~Receive donation form from donor employee and review for completeness and eligibility.~~ • ~~Within ten (10) days of receipt of all necessary material provide notice to donor employee whether or not Human Resources approves or rejects the employee's request. Where approved, convert PTO hour(s) donated to dollars at the base rate of pay of the donor, then convert dollars to PTO hour(s) at the recipient's base rate of pay.~~

~~E.~~C. Reinstatement or Conversion of Paid Sick Leave upon Rehire

Responsible Party	Action

Human Resources Department	• Identify staff who are rehired within one (1) year from date of separation and previously ~~met~~meet the eligibility criteria for Paid Sick Leave.
	  • If rehired as an employee who continues to meet Paid Sick Leave eligibility criteria, determine if employee has previously accrued and unused Paid Sick Leave time to be reinstated, and follow process for reinstatement.
	  • If rehired as a regular employee who is eligible to accrue PTO, determine if employee has previously accrued and unused Paid Sick Leave time balance to be reinstated for use. ~~converted to PTO, and follow process for conversion.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233-234, and 245-249 *et seq*.
B. CalOptima Health Employee Handbook
C. CalOptima Health Policy GA.8037: Leave of Absence
D. CalOptima Health Policy GA.8038: Personal Leave of Absence
E. CalOptima Health Policy GA.8040: FMLA and CFRA Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Program
G. CalOptima Health Policy GA.8059: Attendance and Timekeeping
H. Cash Out PTO for Financial Hardship Request Form
I. Government Code § 12945.2 et seq. (CFRA)
~~J. PTO Donation Program - Request and Authorization Form - Recipient Employee~~
~~K. PTO Donation Program - Donation and Authorization Form - Donor Employee~~
~~L.~~J. Title 2, California Code of Regulations § 11035 et. seq. (Pregnancy Regulations)
~~M.~~K. Title 2, California Code of Regulations § 11087 et seq. (CFRA Regulations)
L. Title 26, Code of Federal Regulations (C.F.R.) § 1.451-2 et seq. (Constructive Receipt of Income)

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~~N.~~M. Title 29, Code of Federal Regulations (C.F.R.) Part 825 et seq. (FMLA Regulations)
~~O.~~N. Title 29, United States Code section 2601 et seq. (FMLA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
10/03/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/2011	GA.8018	Paid Time Off (PTO)	Administrative
Revised	03/26/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	05/01/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	08/07/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	06/04/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	02/02/2017	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2020	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/01/2022	GA.8018	Paid Time Off (PTO)	Administrative
Revised	01/01/2024	GA.8018	Paid Time Off (PTO)	Administrative
Revised	10/03/2024	GA.8018	Paid Time Off (PTO)	Administrative

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IX. GLOSSARY

Term	Definition
As-Needed	Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.
Child	For the purposes of this policy, a biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis. The definition of child is applicable regardless of age or dependency status.
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima Health.
Continuous Service	A period of employment with one (1) employer, which begins with the day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating continuous service.
Designated Person	A term used to describe an individual related to the employee by blood or whose association with the employee is equivalent to a family relationship.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours per pay period.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Limited Term Employee	Employees who are hired to work a full-time schedule on special-assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Paid Sick Leave	Paid Sick Leave covers the provisions of the Healthy Workplaces, Healthy Families Act of 2014 (California Labor Code §245-249) and Kin Care (California Labor Code §233-234)
Parent	For the purposes of this policy, the biological, adoptive, step or foster parent of an employee or the employee's spouse or Registered Domestic Partner, or an individual who stands or stood in loco parentis to an employee when the employee was a child. California Healthy Workplaces, Healthy Families Act of 2014 also includes parents-in-law.

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Term	Definition
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.
Registered Domestic Partner	Registered domestic partners can be any couples, regardless of their sex. Only domestic partners who have registered with the State of California – or who formed a substantially equivalent legal union in another jurisdiction – qualify as Registered Domestic Partners.

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Policy:	GA.8018
Title:	**Paid Time Off (PTO)**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/27/2011
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy provides managers and supervisors with appropriate guidelines to administer CalOptima Health's Paid Time Off (PTO) benefit.

II. POLICY

A. CalOptima Health provides PTO as a work-life balance benefit to all eligible employees to allow them to take time off from work for activities such as rest, recreation, recovery, and other personal activities of various kinds. CalOptima Health believes this time is valuable for employees in order to enhance productivity and make the work experience more personally satisfying. CalOptima Health's PTO program is not intended to and should not be considered to be a salary continuation program. CalOptima Health provides employees with additional hours of PTO as months of service are accumulated.

B. Full-Time, Part-Time, and Limited Term Employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. An eligible employee may use accrued PTO hours to take time off from work for any reason. CalOptima Health encourages employees to maintain work-life balance by utilizing PTO benefits for rest and recreation throughout the year. Employees who satisfy eligibility requirements set out in CalOptima Health's respective policies and applicable federal and state laws may be granted other types of leaves of absence.

C. For all other employees who are not eligible to accrue PTO, CalOptima Health will provide Paid Sick Leave in accordance with the California Healthy Workplaces, Healthy Families Act of 2014, utilizing the lump sum method.

D. **PTO Accrual:** An eligible employee begins accruing PTO on their hire date, based on hours paid each pay period (eligible hours paid not to exceed 80 hours per pay period), and months of Continuous Service in accordance with the accrual schedule provided below. Additional exceptions are outlined in the PTO Guidelines.

1. If a higher accrual rate is awarded during the onboarding process, as outlined in the PTO guidelines, the employee will remain at that accrual rate and not advance to the next tier until their seniority is equal to the next tiers minimum seniority eligibility. The Chief

Executive Officer may also approve additional modifications for position-based accrual levels as outlined in the PTO Guidelines.

E. **Annual Paid Time Off Benefits Accrual Schedule**

(Effective the Pay Period that Includes January 4, 2027)

In the accrual table below, the total hours accrued are based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period. The increase in PTO accrual will take effect at the end of the pay period following completion of service as shown in the table below.

Tier	Seniority	Hours of PTO Accrued (Biweekly pay period)	Approximate Annual Accrual	Maximum Accrual
1	Up to 36 Months	7.08	184	368
2	36+ Months to 120 Months	8.62	224	448
3	120+ Months	10.16	264	528

Note: 36 Months = 3 years; 120 months = 10 years

F. **Maximum Accrual:** Limits are imposed on the amount of PTO that can be maintained in an employee's PTO account. If available, PTO is not used by the end of the benefit year [benefit year is the twelve (12) month period from hire date], employees may carry unused time off into subsequent years, up to the maximum accrual amount specified herein. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's Annual Accrual (see chart above). If an employee reaches their maximum PTO accrual amount, the employee will stop accruing PTO.

G. **PTO Accrual during Leaves of Absence:** PTO does not accrue when absent from work in connection with an approved or unapproved unpaid Leave of Absence, including, but not limited to, workers' compensation leave, or short/long term disability. PTO accruals resume when the employee returns to work from an unpaid Leave of Absence.

H. **PTO Scheduling**: Scheduling of PTO is to be done in a manner compatible with CalOptima Health's operational requirements. In order to minimize the impact of an employee's absence, planned time off should be submitted by an employee to their immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO. Supervisors have authority to approve or deny PTO requests based on business needs, and CalOptima Health will not be responsible for any expenses incurred by an employee if the request for PTO is not approved. Each department may have special scheduling requirements and procedures for requesting PTO; therefore, employees should check with their immediate supervisor in advance, except for purposes of sick leave. In rare cases, an Executive may authorize the rescission of approved PTO to address urgent, emergent, or emergency situations. Notification to the employee will be made as soon as the need is known.

I. **PTO Usage During Leaves of Absence:** Employees are required to use available accrued PTO to cover any period of an approved leave of absence that would otherwise be unpaid, subject to applicable federal and state laws. When an employee is receiving disability benefits, the employee may elect to use accrued PTO to supplement their disability benefit in accordance with CalOptima

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Health's Leave of Absence policies. The combined compensation received from disability benefits and PTO shall not exceed 100% of the employee's regular base salary.

J. **Unscheduled PTO**: Regardless of the reason for an unscheduled absence, an employee shall notify their immediate supervisor in accordance with CalOptima Health Policy GA.8059: Attendance and Timekeeping. Notification of an unscheduled absence does not make the absence authorized. An employee shall enter the PTO request into the timekeeping system as soon as reasonably possible, and the employee's PTO account will be deducted accordingly. If an employee is absent for six (6) consecutive days or more on personal and unprotected sick time, a doctor's note is required on the first day back. Excessive use of unscheduled PTO may result in discipline, up to and including termination.

K. **Holidays Occurring During PTO**: If an observed CalOptima Health holiday occurs during an employee's scheduled PTO, the employee's PTO account will not be deducted for that holiday day, unless the full-time Non-Exempt Employee is on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule. In this case, the employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor.

L. **Maximum Annual Cash Out**: An election period will be held each year at about the same time as CalOptima Health's annual open enrollment period. During this time, each employee may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee may be eligible to accrue at the time of cash out in the next calendar year. Once the election period closes, but in no event after December 31 of the year prior to payment of the cash out, the request for PTO cash out cannot be revoked. Requests for cash out will be paid out once per calendar year as determined by the Human Resources Department, provided that all of the following criteria are met:

1. The employee made the election during the applicable open enrollment period; and

2. The employee has actually accrued the requested number of hours in the same year and by the time the cash out is made; and

3. A minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out.

    a. If the employee's election to cash out is for more hours than are eligible, the cash out will be limited to the number of eligible PTO hours at the time the cash out is made.

4. Cashed out PTO will be paid at the employee's current hourly rate during the second pay period in November each year, subject to all applicable taxes and deductions.

M. **Cash Out for Financial Hardship:** If during the year an employee experiences a personal financial hardship, the employee can cash out their accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need and there must be no other resources readily available to handle that financial need. Financial hardships shall be limited to the following reasons:

1. Expenses for, or necessary, to obtain non-reimbursed medical care for employee or immediate family members;

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2. Payment for the purchase of a primary residence;

3. Payment of tuition, related education fees, and room and board expenses for postsecondary education for the employee, or the employee's spouse (or Registered Domestic Partner), a Child, or dependents;

4. Payments necessary to prevent the employee from eviction or foreclosure;

5. Expenses for the repair of damage to an employee's primary residence for damages from natural disasters; or

6. Expenses for the burial, funeral, or memorial for an employee's deceased Parent, spouse (or Registered Domestic Partner), Child, or dependents.

N. **PTO Pay/Flex Pay on Termination**: Employees are expected to give at least two (2) weeks' written notice prior to resigning from their employment. Notice of resignation is expected to be a "working" notice to allow an opportunity for productive work time to complete projects, or train whoever will be assuming the employee's responsibilities. For that reason, employees should avoid using accrued PTO during the two (2) week period preceding their last scheduled day of work and/or coordinate the use of PTO hours to provide at least two (2) "working" weeks. In no event shall CalOptima Health permit an employee to use their accrued PTO beyond the last day worked by an employee, unless the employee was on an approved Leave of Absence, or unless otherwise required by law. Upon termination of employment, the employee is paid all accrued unused PTO and Flex Holiday time at the employee's base rate of pay, subject to all applicable taxes, at the time of the termination. According to California Labor Code, Section 220(b), as a public agency, CalOptima Health is not required to pay wages immediately upon termination. CalOptima Health will pay the employee on the next regularly scheduled pay day.

III. PROCEDURE

A. PTO Request for Time Off:

Responsible Party	Action
Employee	• Request PTO at least two (2) weeks in advance, where possible, using CalOptima Health's time-keeping system. If the need for time off is foreseeable, employees must provide reasonable advance notice. If not, the employee must provide notice as soon as practicable. PTO should be entered using the most appropriate PTO code based on the absence.
Supervisor	• Review all requests and approve, or deny, the request.

B. PTO Request to Cash Out:

Responsible Party	Action
Employee	• Request PTO cash out for the following year during the designated election period
Payroll	• Review all requests and approve or deny the request.

C. Reinstatement or Conversion of Paid Sick Leave upon Rehire

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Responsible Party	Action

Human Resources Department	• Identify staff who are rehired within one (1) year from date of separation and previously meet the eligibility criteria for Paid Sick Leave.
	  • If rehired as an employee who continues to meet Paid Sick Leave eligibility criteria, determine if employee has previously accrued and unused Paid Sick Leave time to be reinstated, and follow process for reinstatement.
	  • If rehired as a regular employee who is eligible to accrue PTO, determine if employee has previously accrued and unused Paid Sick Leave time balance to be reinstated for use.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233-234, and 245-249 *et seq*.
B. CalOptima Health Employee Handbook
C. CalOptima Health Policy GA.8037: Leave of Absence
D. CalOptima Health Policy GA.8038: Personal Leave of Absence
E. CalOptima Health Policy GA.8040: FMLA and CFRA Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Program
G. CalOptima Health Policy GA.8059: Attendance and Timekeeping
H. Cash Out PTO for Financial Hardship Request Form
I. Government Code § 12945.2 et seq. (CFRA)
J. Title 2, California Code of Regulations § 11035 et. seq. (Pregnancy Regulations)
K. Title 2, California Code of Regulations § 11087 et seq. (CFRA Regulations)
L. Title 26, Code of Federal Regulations (C.F.R.) § 1.451-2 et seq. (Constructive Receipt of Income)
M. Title 29, Code of Federal Regulations (C.F.R.) Part 825 et seq. (FMLA Regulations)
N. Title 29, United States Code section 2601 et seq. (FMLA)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/02/2023	Regular Meeting of the CalOptima Health Board of Directors
10/03/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

For 20261105 PCDReviewOnly

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/2011	GA.8018	Paid Time Off (PTO)	Administrative
Revised	03/26/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	05/01/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	08/07/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	06/04/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	02/02/2017	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2020	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/01/2022	GA.8018	Paid Time Off (PTO)	Administrative
Revised	01/01/2024	GA.8018	Paid Time Off (PTO)	Administrative
Revised	10/03/2024	GA.8018	Paid Time Off (PTO)	Administrative

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IX. GLOSSARY

Term	Definition
As-Needed	Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.
Child	For the purposes of this policy, a biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis. The definition of child is applicable regardless of age or dependency status.
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima Health.
Continuous Service	A period of employment with one (1) employer, which begins with the day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating continuous service.
Designated Person	A term used to describe an individual related to the employee by blood or whose association with the employee is equivalent to a family relationship.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours per pay period.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Limited Term Employee	Employees who are hired to work a full-time schedule on special-assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Paid Sick Leave	Paid Sick Leave covers the provisions of the Healthy Workplaces, Healthy Families Act of 2014 (California Labor Code §245-249) and Kin Care (California Labor Code §233-234)
Parent	For the purposes of this policy, the biological, adoptive, step or foster parent of an employee or the employee's spouse or Registered Domestic Partner, or an individual who stands or stood in loco parentis to an employee when the employee was a child. California Healthy Workplaces, Healthy Families Act of 2014 also includes parents-in-law.

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Term	Definition
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.
Registered Domestic Partner	Registered domestic partners can be any couples, regardless of their sex. Only domestic partners who have registered with the State of California – or who formed a substantially equivalent legal union in another jurisdiction – qualify as Registered Domestic Partners.

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Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima Health considers the following as Special Compensation pursuant to Title 2, California Code of Regulations (CCR), Section 571:

1. Holiday Premium Pay;

~~1.~~2. Bilingual Pay/Bilingual Premium;

~~2.~~1. ~~Holiday Premium Pay;~~

3. Night Shift ~~Premium/Shift~~ Differential Pay;

4. ~~Active~~ Certified Case Manager Pay (CCM~~) Pay/~~)/ Educational Incentive; and

5. Temporary Assignment Pay (TAP); and

~~5.~~6. Temporary Upgrade Pay (TUP).

B. Overtime Pay: As a public agency, CalOptima Health follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all time worked in excess of forty (40) in any one (1) federal Fair Labor Standards Act (FLSA) workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by FLSA. Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: 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 under GA.8056 Paid

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Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is only considered holiday pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for employees who are normally required to work on an approved holiday because they work in positions that require scheduled staffing without regard to holidays.

D. Bilingual Pay: CalOptima Health provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima Health's Threshold Languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate paid to the Bilingual Certified Employee based on the following schedule:

Proficiency	Rate Per Pay Period (Full-Time)	Rate Per Pay Period (Part-Time)
Bilingual language usage with members is required and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00	$30.00
Bilingual language usage with members is required and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00	$20.00

~~E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Health members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.~~

~~1. Exempt Employees, who do not work in the Cultural & Linguistic Services Department (C&L) and who are not required as part of their regular job responsibilities to translate but are qualified to translate based on successfully passing the CalOptima Health Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during their own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.~~

~~2. There are two (2) key activities in providing translation services:~~

~~a. Translation of materials from English into the desired language, or from another language into English; and~~

~~b. Review and revision of the translation to ensure quality and consistency in usage of terms.~~

~~3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima Health will reimburse for services at the following rates:~~

~~a. Translation – Thirty-five dollars ($35.00) per page; and~~

~~b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.~~

~~4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.~~

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F.E. Night Shift Differential Pay: CalOptima Health provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima Health management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift Differential Pay is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) hours or more of workShift start time between 3 p.m. and 8 a11 p.m.	All Non-exempt employees	$2.00 per hour

G.F. Call Back and On Call Accessible and On Call Working: CalOptima Health provides supplemental pay for work performed as part of a Call Back andan On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima Health management. Employees must ensure all On Call time is properly documented and approved. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
On Call Accessible - Employees scheduled for On Call Accessible must remain reachable outside their regularly scheduled work shifts and be available to report to work or address operational needs, as determined necessary by management. While On Call Accessible, employees are not actively engaged in work duties and are free to use their time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.Call Back – Employees must physically return to their worksite within one (1) hour when requested by a Supervisor, after their regular shift has ended and they have physically left the workplace. A Supervisor may assign employees other work until the minimum of four (4) hours has elapsed.	All Non-exempt employees	One and one half (1.5) times of regular base pay with a minimum of four (4) hours of pay.$3.00 per hour
On Call Working – Employees must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employees will be informed of the need for their availabilitywho are On Call Accessible and are called to work either from home or at the work site. Employees will be considered in a status of "on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called. working".Employees must respond within one (1) hour, as required.	All Non-exempt employees	$3.00 per hour for being on call waiting. If a call is taken, employee is on call working and paidPaid one and one half (1.5) times the regular base pay, with a thirty (30) minute minimumon call. guarantee

H.G. Commuter Allowance: With approval of the Chief Executive Officer (CEO), the Commuter Allowance may be offered each fiscal year to provide an amount of one hundred fifty dollars ($150.00) per pay period to Full-Time Employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to Full-Time Employees designated as Partial Teleworkers. For new hires, the Commuter Allowance begins with the first full pay period of their employment. For changes to telework status, any resulting change to the Commuter Allowance begins the first Full Pay Period as a Full Office Worker or Partial Teleworker. Eligible Full-Time Employees will continue to receive the Commuter Allowance until the first Full Pay Period in which an employee is

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not assigned to partial telework or full office work. The Commuter Allowance will be provided only for Full Pay Periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the Commuter Allowance. The Commuter Allowance may be paused and resumed at the discretion of the CEO.

~~I.~~H. Internet Stipend: CalOptima Health shall provide an Internet Stipend in the amount of twenty-five dollars ($25.00) per pay period ~~to~~for Full-Time Employees and eighteen dollars seventy-five cents ($18.75) to Part-Time Employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first Full Pay Period as a Full or Partial Teleworker or Community Worker. Eligible Full-Time Employees will continue to receive the stipend until the first, Full Pay Period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for Full Pay Periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

~~J.~~I. ~~Active~~ Certified Case Manager Pay (CCM~~) Pay:~~): CalOptima Health may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an employee who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This will not be prorated for partial pay periods. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

~~K.~~J. Executive Incentive ~~Plan~~: The Chief Executive Officer (CEO) may recognize Executive Level Positions, including interim appointments, using incentive pay for employees in Executive Level Positions who achieve outstanding performance. Detailed elements of this program are available in the CalOptima Health Executive Incentive Plan Guidelines.

~~L.~~K. Employee Sales and Enrollment Incentive Program. Changes to this plan will be effective July 1, 2024. The purpose of the Program is to provide incentives for qualified and eligible staff whose primary job responsibility is to enroll new members in CalOptima Health's competitive programs, OneCare, Program for All-Inclusive Care for the Elderly (PACE), and Covered California. Employees eligible for the Program must be employed by CalOptima Health, in good standing. Eligible employees must also individually sign a Sales and Enrollment Incentive Program Agreement, which does not alter the at-will nature of their relationship with CalOptima Health. The Sales and Enrollment Incentive Program may be modified or withdrawn, at any time, with five days' advance written notice.

1. OneCare Program: The OneCare Program Sales team leaders and staff must have an active Resident Insurance Producer license to enroll eligible members into the OneCare program. These licensed employees may be eligible to receive an incentive payment based on the number of new enrollments produced and retained in the OneCare program on a monthly basis in accordance with the OneCare Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

2. PACE Program: The PACE Sales and Enrollment team leaders and staff are eligible for the Sales and Enrollment Incentive Program and may receive incentive payments based on the number of new enrollments produced and retained in the PACE Program on a monthly basis in accordance with the PACE Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

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3. Covered California Program: The Covered California Sales team leaders and staff are eligible for the Covered California Incentive Program and may receive incentive payouts based on the number of new enrollments produced and retained in the Covered California Program on a monthly basis in accordance with the Covered California Incentive Program Agreement signed by each eligible employee.

~~M. Employee~~ Incentive ~~Program~~Programs: At the discretion of the CEO~~, specific employees~~ and subject to budget availability, individuals may be ~~recognized through~~granted incentive compensation, when doing so is consistent with CalOptima Health's business needs and mission, vision, and values.

~~N. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima Health may, at the discretion of the CEO, and on an exceptional basis, award a retention incentive.~~

~~O. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima Health. Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approval.~~

~~P.~~L. Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. An award of incentive compensation in one (1) year is not indicative or a guarantee of future awards of incentive compensation and does not alter the at-will nature of employment at CalOptima Health.

1. CalRecognition Award: At the discretion of the CEO, monetary recognition, not to exceed $2,000 per employee per award, may be paid to employees for demonstrating excellence and dignity in service to our members or for an extraordinary organization-wide contribution(s).

2. Sign-on Incentive: At the discretion of the CEO, a sign-on incentive of up to a maximum of fifty thousand dollars ($50,000) may be offered to entice an individual to join CalOptima Health. Sign-on incentives require informing the Board of Directors after approval.

3. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima Health may, at the discretion of the CEO, and on an exceptional basis, award a retention incentive. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors' approval.

4. Service Award: Employee recognition to honor the completed years of public employment in the service to CalOptima Health who have achieved significant career milestones. At the discretion of the CEO, employees may receive $2,000 after 20 years of CalOptima Health service, plus $500 for every additional 5 years of service.

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~~Q.~~M. Employer-Paid Member Contribution (EPMC): CalOptima Health contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima Health salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to January 1, 2013, of another California public retirement system that is eligible for reciprocity with CalPERS.

~~R.~~N. ~~Annual Performance~~Merit Lump Sum Bonus: ~~Employees paid at or above the pay range maximum are not eligible for future~~Merit pay will typically be an increase to base pay ~~increases. As a result, in lieu of future base pay increases, these employees~~; however, it may ~~be eligible for merit Bonus Pay~~also be delivered as ~~a~~ lump sum bonus ~~in accordance with Section III.N. of this Policy, provided that~~ for employees paid at or above the pay range maximum of their ~~performance meets the goals~~position. Merit Lump Bonus eligibility and ~~objectives set forth by their managers~~calculation are described in Reference I: Compensation Administration Guidelines.

~~S.~~O. Automobile Allowance: CalOptima Health may, at the discretion of the CEO, provide employees in Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima Health business.

~~T.~~P. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima Health's contribution rate for employees to a 401(a) tax-qualified supplemental retirement benefit (SRB) plan within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in Executive Level Positions, the contribution rate shall be uniform for all employees. Executive Level Positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to the 401(a) SRB plan, subject to the limitations of applicable laws. An employee in an Executive Level Position must still be employed by CalOptima Health at the time the additional supplemental contribution is distributed in order to be eligible to earn and receive the additional supplemental contributions. Government Code Sections 7522.72 and 7522.74 require the forfeiture of all accrued rights and benefits in any public retirement system by any public employee convicted of any job-related felony, as of the earliest date of the crime.

~~U.~~Q. Work Life Balance Stipend: CalOptima Health shall provide an annual Work Life Balance Stipend of five hundred dollars ($500.00) to Full-Time Employees and two hundred fifty dollars ($250.00) to Part-Time Employees. The stipend is intended to promote employee wellness through enhanced work life balance and may be used for any wellness-related purchases, such as dependent care, gym memberships, yoga classes, art therapy, dietician services, athletic gear, personal development courses, and more. The stipend is taxable and paid in two (2) increments of two hundred fifty dollars ($250.00) to Full-Time Employees and one hundred twenty-five dollars ($125.00) to Part-Time Employees on the pay periods that include November 01, and May 01 each year.

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~~V.~~R. Benefit Income: CalOptima Health shall provide a bi-monthly taxable medical stipend as a cost savings measure to CalOptima Health and incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit. The amount of the bi-monthly stipend is approved by the Board of Directors on an annual basis.

~~W.~~S. ~~Temporary Upgrade Pay: (~~TUP~~):~~ An employee who is appointed for a limited duration to a job having a higher pay grade is eligible for ~~Temporary Upgrade Pay~~TUP. The employee must meet the minimum requirements of the position and be performing all essential job functions and responsibilities of the upgraded position without performing duties of their current job to qualify for ~~Temporary Upgrade Pay. Temporary Upgrade Pay~~TUP. TUP will be the minimum of the new pay rate or a five percent (5%) of the base pay increase, whichever is greater. ~~Temporary Upgrade Pay~~TUP will be eliminated when the temporary assignment ends~~.~~ and incumbent will return to their previous pay grade. The temporary assignment shall not exceed nine hundred and sixty (960) hours. ~~Temporary Upgrade Pay~~TUP is considered premium pay pursuant to Title 2 CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members only.

T. ~~Temporary Assignment Pay (~~TAP~~):~~ At the discretion of the CEO, an employee assigned higher-level duties for a limited duration may receive TAP either (1) as supplemental pay in addition to TUP when the TUP amount calculated under Section II.S does not provide compensation appropriate for the temporary assignment, or (2) as an alternative to TUP when the employee does not satisfy the eligibility requirements for TUP or when the CEO determines that an alternative compensation approach is appropriate. TAP will be based on the employee's qualifications, internal pay practices, and other relevant business considerations. When TAP is paid in addition to TUP, TAP will equal the difference between the employee's pay rate after application of TUP and the total temporary pay rate approved by the CEO. In all cases, the employee's total temporary pay rate may not exceed the maximum rate of the pay grade for the higher-level position or assignment. TAP will end when the temporary assignment or higher-level duties end. TAP is not considered Special Compensation for CalPERS reporting.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima Health observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not eligible for Holiday Premium Pay and will be paid at the employee's regular base pay. Actual hours worked on a holiday will be used for purposes of calculating overtime.

C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal language fluency evaluation when bilingual proficiency is a required part of the employee's or potential employee's job and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, bilingual pay shall be established. For new hires, the Bilingual Pay begins with the first pay period of their employment. Changes to Bilingual Pay will occur at the start of a pay period. Bilingual pay shall not be prorated. Temporary and/or interim assignments will not impact bilingual pay.

~~D. Translation Pay: If an eligible Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay identified above will be provided depending on~~

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~~the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.~~

~~E.~~D. Night Shift Differential:

1. Night Shift ~~differential~~Differential is automatically calculated for those employees regularly working a night shift~~, defined as seven (7) hours or more of work between 3:00 p.m. and 8:00 a.m.~~.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting to make up time or work alternative hours, and as a result, would be eligible for night shift differential pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

~~F.~~E. On Call ~~Back~~Accessible and On Call Working Pay:

1. If employees are on call or get called back to work, the employees are responsible for adding this time to their schedules through CalOptima Health's time keeping system, which is then approved by their supervisors.

~~G.~~F. Commuter Allowance:

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima Health may periodically audit and validate employee Office/Telework designations.

~~H.~~G. Internet Stipend:

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima Health may periodically audit and validate employee Office/Telework designations.

~~I.~~H. ~~Active~~ Certified Case Manager Pay (CCM~~) Pay:~~):

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department. Temporary and/or interim assignments will not impact CCM pay.

~~J.~~I. Executive Incentive Plan:

1. The Board of Directors approves CalOptima Health's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Level Positions. CalOptima Health's Executive Incentive Pay Plan will be administered in accordance with the CalOptima Health Executive Incentive Plan Guidelines.

~~K.~~J. Employee Sales and Enrollment Incentive Program:

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1. The Executive Director, Medicare Programs or designee will review the Employee Sales and Enrollment Incentive structure for the OneCare, PACE, Covered California Programs on at least an annual basis and will submit any required changes to the incentive structure and the OneCare, PACE, and Covered California Employee Sales and Enrollment Incentive Agreements for review and approval by the CEO, or designee.

2. OneCare:

   a. Employees eligible for the Sales and Enrollment Incentive Program will be required to sign a OneCare Sales and Enrollment Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific each eligible employee job title.

   b. The OneCare Director will be responsible for calculating monthly payments for employees who are eligible for the OneCare Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the OneCare Sales and Enrollment Incentive Agreement effective at the time the enrollments are produced. The Director will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

3. PACE:

   a. PACE Employees eligible for the Sales and Enrollment Incentive Program will be required to sign a PACE Sales Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

   b. The PACE Manager Marketing & Enrollment will be responsible for calculating monthly incentive payments for employees who are eligible for the PACE Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the PACE Sales and Enrollment Incentive Program Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

4. Covered California:

   a. Employees eligible for the Covered California Incentive Program will be required to sign a Covered California Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

   b. The Director Operations Management will be responsible for calculating monthly incentive payments for employees who are eligible for the Covered California Incentive Program based on the number of enrollments produced each month according to the terms of the Covered California Incentive Program Agreement effective at the time the enrollments are produced. The Director will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

K. CalRecognition Award: As circumstances warrant, any leader who observed another employee demonstrating exceptional CARES values in the workplace may nominate that individual for this incentive. The nomination is sent by email with a supporting description of the achievement through

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the employee's department's reporting structure. The area Chief may provide the final nomination to the CEO. The CEO makes the final approval if any and determines the incentive amount. If approved by the CEO, the incentive is processed into payroll, and the certificate is prepared by Human Resources for the issuing department leader.

L. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. ~~The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors' approval.~~

M. ~~Recruitment~~Sign-on Incentive: As circumstances warrant, the CEO may offer a ~~recruitment~~sign-on incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima Health. ~~Recruitment incentives of up to a maximum of fifty thousand dollars ($50,000) may be offered for Executive Level Positions and require informing the Board of Directors after approved. To receive the recruitment~~To receive the sign-on incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a ~~recruitment~~sign-on incentive to return the full amount of the ~~recruitment~~sign-on incentive if the recipient voluntarily terminates employment with CalOptima Health within twenty-four (24) months of the date of hire.

N. ~~Annual Performance~~Service Award: Employees earn years of service credit toward this award through each complete year of employment with CalOptima Health. Service years do not have to be consecutive for purposes of Service Award. At the discretion of the CEO, Service Awards are issued annually to eligible employees to celebrate their long-term commitment to the agency and our members.

~~N.~~O.Merit Lump Sum Bonus: Once employees have reached the pay range maximum, employees may be eligible for merit Bonus Pay delivered as a lump sum bonus, provided that their annual performance evaluations meet the established goals and objectives set forth by their managers. Merit Bonus Pay will not exceed the maximum percentage of the merit increase matrix and reflects employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima Health to be eligible to earn and receive the lump sum bonus payments.

~~O.~~P. Automobile Allowance: As circumstances warrant, the CEO may offer employees in Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the employees' W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the employee must comply with the following requirements:

1. Maintain adequate levels of personal vehicle insurance coverage;

2. Purchase their own fuel for the vehicle; and

3. Ensure the vehicle is properly maintained.

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~~P.~~Q. Work Life Balance Stipend: Work Life Balance Stipend is automatically calculated for eligible employees. To be eligible, employees must be in active status (either working or on a paid LOA) in the pay period that includes May 1 or November 1. Employees on an approved, unpaid LOA when the Work Life Balance Stipend is paid will receive a retroactive payment upon return to active status.

~~Q.~~R. Benefit Income: Once enrolled in Benefit Income, the participating employee's election to waive CalOptima Health medical insurance will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event. Benefit Income may be temporarily suspended for employees who are on an approved Leave of Absence (LOA) without pay in accordance with CalOptima Health Policies GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation, GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, GA.8041: Workers' Compensation Program, or GA.8063: Disability Accommodations. However, retroactive payment for Benefit Income will be applied for the period of protected, unpaid leave upon return to active duty.

~~R.~~S. ~~Temporary Upgrade Pay: (~~TUP~~):~~ Human Resources will calculate ~~Temporary Upgrade Pay~~TUP for eligible employees who are authorized and appointed for a limited duration to assume the duties of a position with a higher pay grade.

T. ~~Temporary Assignment Pay (~~TAP~~):~~ As circumstances warrant, the CEO may approve TAP, including whether it will be paid in addition to TUP or as an alternative to TUP and the approved total temporary pay rate. Human Resources will determine and document eligibility, calculate the TAP amount, confirm that the employee's total temporary pay rate does not exceed the applicable pay-grade maximum, and provide the approved amounts and effective dates to Payroll. Human Resources will review any change in the assignment that may affect eligibility or the approved amount. TAP will be discontinued when the approved temporary assignment or higher-level duties end.

~~S.~~U. Supplemental Compensation During Leave of Absence: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift ~~Premium, Call Back or~~Differential, On Call Pay, ~~Active~~ Certified Case Manager Pay (CCM~~) Pay,~~), Internet Stipend, Commuter Allowance, or Automobile Allowance during their LOA. If applicable, an employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution, Supplemental Retirement Benefit and Benefit Income during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid for eligibility. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

~~T.~~V. Proration: For supplemental compensation that is paid per pay period and not based on hourly pay rate (i.e. Bilingual Pay, Active Certified Case Manager, Internet Stipend, Commuter Allowance, Automobile Allowance, and Benefit Income), such compensation will begin the first Full Pay Period after eligibility is established. These items of compensation will be provided only for Full Pay Periods and will not be prorated for a change in eligibility for a portion of the pay period.

~~U.~~W. Supplemental Compensation for Part-Time Employees

1. If eligible, regular Part-Time Employees will receive pro-rated supplemental compensation based on their approved work schedule, as reflected in the timekeeping system, for the following:

    a. ~~Active~~ Certified Case Manager Pay (CCM) / Educational Incentive;

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b. Executive Incentive Pay Plan;

c. ~~Annual~~ Merit Lump Sum Bonus;

d. Automobile Allowance; and

e. Benefit Income.

2. Exceptions include the following:

a. Bilingual Pay, Internet Stipend and Work Life Balance Stipends will be paid in accordance with Section II.

~~V.~~X. Part-Time Employees are not eligible for the Commuter Allowance.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. CalOptima Health Executive Incentive Plan Guidelines
C. CalOptima Health Performance Review of Executives Template
D. CalOptima Health Policy GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation
E. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Program
G. CalOptima Health Policy GA.8056: Paid Holidays
H. CalOptima Health Policy GA.8063: Disability Accommodations
I. Compensation Administration Guidelines
J. Covered California Sales and Enrollment Incentive Program Agreements
K. Government Code, §20636 and 20636.1
L. OneCare Sales and Enrollment Incentive Program Agreements
M. PACE Sales and Enrollment Incentive Program Agreements
N. Telework Program Guidelines
O. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors
06/04/2026	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative
Revised	06/02/2022	GA.8042	Supplemental Compensation	Administrative
Revised	05/04/2023	GA.8042	Supplemental Compensation	Administrative
Revised	12/07/2023	GA.8042	Supplemental Compensation	Administrative
Revised	06/06/2024	GA.8042	Supplemental Compensation	Administrative
Revised	06/05/2025	GA.8042	Supplemental Compensation	Administrative
Revised	06/01/2026	GA.8042	Supplemental Compensation	Administrative
Revised		GA.8042	Supplemental Compensation	Administrative

For 2026

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima Health's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by the Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima Health's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by the C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Community Worker	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Continuous Leave of Absence (LOA)	Leave that is taken uninterruptedly, rather than intermittently.
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Pay Period	A Full Pay Period refers to all of an employee's scheduled work hours within a pay period.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Full-Time Employees	For purposes of this policy, employees who are regularly scheduled to work thirty (30) hours or more per week.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.

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Term	Definition
Night Shift	Regularly scheduled shifts with start time between 3 p.m. and 11 p.m.
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Part-Time Employees	Employees who are regularly scheduled to work less than thirty (30) hours per week.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare, PACE, or Covered California Programs.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	A threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

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Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima Health considers the following as Special Compensation pursuant to Title 2, California Code of Regulations (CCR), Section 571:

1. Holiday Premium Pay;
2. Bilingual Pay/Bilingual Premium;
3. Night Shift Differential Pay;
4. Certified Case Manager Pay (CCM)/ Educational Incentive; and
5. Temporary Assignment Pay (TAP); and
6. Temporary Upgrade Pay (TUP).

B. Overtime Pay: As a public agency, CalOptima Health follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all time worked in excess of forty (40) in any one (1) federal Fair Labor Standards Act (FLSA) workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by FLSA. Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: 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 under GA.8056 Paid Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is only considered holiday

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pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for employees who are normally required to work on an approved holiday because they work in positions that require scheduled staffing without regard to holidays.

D. Bilingual Pay: CalOptima Health provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima Health's Threshold Languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate paid to the Bilingual Certified Employee based on the following schedule:

Proficiency	Rate Per Pay Period (Full-Time)	Rate Per Pay Period (Part-Time)
Bilingual language usage with members is required and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00	$30.00
Bilingual language usage with members is required and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00	$20.00

E. Night Shift Differential Pay: CalOptima Health provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima Health management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift Differential Pay is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Shift start time between 3 p.m. and 11 p.m.	All Non-exempt employees	$2.00 per hour

F. On Call Accessible and On Call Working: CalOptima Health provides supplemental pay for work performed as part of an On Call requirement. Assignments for On Call are subject to business needs and are at the discretion of CalOptima Health management. Employees must ensure all On Call time is properly documented and approved. The rates for On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
On Call Accessible - Employees scheduled for On Call Accessible must remain reachable outside their regularly scheduled work shifts and be available to report to work or address operational needs, as determined necessary by management. While On Call Accessible, employees are not actively engaged in work duties and are free to use their time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.	All Non-exempt employees	$3.00 per hour
On Call Working – Employees who are On Call Accessible and are called to work either from home or at the work site will be considered in a status of "on call working".	All Non-exempt employees	Paid one and one half (1.5) times the regular base pay, with a thirty (30) minute on call guarantee

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G. Commuter Allowance: With approval of the Chief Executive Officer (CEO), the Commuter Allowance may be offered each fiscal year to provide an amount of one hundred fifty dollars ($150.00) per pay period to Full-Time Employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to Full-Time Employees designated as Partial Teleworkers. For new hires, the Commuter Allowance begins with the first full pay period of their employment. For changes to telework status, any resulting change to the Commuter Allowance begins the first Full Pay Period as a Full Office Worker or Partial Teleworker. Eligible Full-Time Employees will continue to receive the Commuter Allowance until the first Full Pay Period in which an employee is not assigned to partial telework or full office work. The Commuter Allowance will be provided only for Full Pay Periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the Commuter Allowance. The Commuter Allowance may be paused and resumed at the discretion of the CEO.

H. Internet Stipend: CalOptima Health shall provide an Internet Stipend in the amount of twenty-five dollars ($25.00) per pay period for Full-Time Employees and eighteen dollars seventy-five cents ($18.75) to Part-Time Employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first Full Pay Period as a Full or Partial Teleworker or Community Worker. Eligible Full-Time Employees will continue to receive the stipend until the first, Full Pay Period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for Full Pay Periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

I. Certified Case Manager Pay (CCM): CalOptima Health may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an employee who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This will not be prorated for partial pay periods. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

J. Executive Incentive Plan: The Chief Executive Officer (CEO) may recognize Executive Level Positions, including interim appointments, using incentive pay for employees in Executive Level Positions who achieve outstanding performance. Detailed elements of this program are available in the CalOptima Health Executive Incentive Plan Guidelines.

K. Employee Sales and Enrollment Incentive Program. Changes to this plan will be effective July 1, 2024. The purpose of the Program is to provide incentives for qualified and eligible staff whose primary job responsibility is to enroll new members in CalOptima Health's competitive programs, OneCare, Program for All-Inclusive Care for the Elderly (PACE), and Covered California. Employees eligible for the Program must be employed by CalOptima Health, in good standing. Eligible employees must also individually sign a Sales and Enrollment Incentive Program Agreement, which does not alter the at-will nature of their relationship with CalOptima Health. The Sales and Enrollment Incentive Program may be modified or withdrawn, at any time, with five days' advance written notice.

1. OneCare Program: The OneCare Program Sales team leaders and staff must have an active Resident Insurance Producer license to enroll eligible members into the OneCare program. These licensed employees may be eligible to receive an incentive payment based on the number of new enrollments produced and retained in the OneCare program on a monthly basis in accordance with the OneCare Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

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2. PACE Program: The PACE Sales and Enrollment team leaders and staff are eligible for the Sales and Enrollment Incentive Program and may receive incentive payments based on the number of new enrollments produced and retained in the PACE Program on a monthly basis in accordance with the PACE Sales and Enrollment Incentive Program Agreement signed by each eligible employee.

3. Covered California Program: The Covered California Sales team leaders and staff are eligible for the Covered California Incentive Program and may receive incentive payouts based on the number of new enrollments produced and retained in the Covered California Program on a monthly basis in accordance with the Covered California Incentive Program Agreement signed by each eligible employee.

L. Incentive Programs: At the discretion of the CEO and subject to budget availability, individuals may be granted incentive compensation, when doing so is consistent with CalOptima Health's business needs and mission, vision, and values. Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. An award of incentive compensation in one (1) year is not indicative or a guarantee of future awards of incentive compensation and does not alter the at-will nature of employment at CalOptima Health.

1. CalRecognition Award: At the discretion of the CEO, monetary recognition, not to exceed $2,000 per employee per award, may be paid to employees for demonstrating excellence and dignity in service to our members or for an extraordinary organization-wide contribution(s).

2. Sign-on Incentive: At the discretion of the CEO, a sign-on incentive of up to a maximum of fifty thousand dollars ($50,000) may be offered to entice an individual to join CalOptima Health. Sign-on incentives require informing the Board of Directors after approval.

3. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima Health may, at the discretion of the CEO, and on an exceptional basis, award a retention incentive. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors' approval.

4. Service Award: Employee recognition to honor the completed years of public employment in the service to CalOptima Health who have achieved significant career milestones. At the discretion of the CEO, employees may receive $2,000 after 20 years of CalOptima Health service, plus $500 for every additional 5 years of service.

M. Employer-Paid Member Contribution (EPMC): CalOptima Health contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima Health salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

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2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to January 1, 2013, of another California public retirement system that is eligible for reciprocity with CalPERS.

N. Merit Lump Sum Bonus: Merit pay will typically be an increase to base pay; however, it may also be delivered as lump sum bonus for employees paid at or above the pay range maximum of their position. Merit Lump Bonus eligibility and calculation are described in Reference I: Compensation Administration Guidelines.

O. Automobile Allowance: CalOptima Health may, at the discretion of the CEO, provide employees in Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima Health business.

P. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima Health's contribution rate for employees to a 401(a) tax-qualified supplemental retirement benefit (SRB) plan within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in Executive Level Positions, the contribution rate shall be uniform for all employees. Executive Level Positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to the 401(a) SRB plan, subject to the limitations of applicable laws. An employee in an Executive Level Position must still be employed by CalOptima Health at the time the additional supplemental contribution is distributed in order to be eligible to earn and receive the additional supplemental contributions. Government Code Sections 7522.72 and 7522.74 require the forfeiture of all accrued rights and benefits in any public retirement system by any public employee convicted of any job-related felony, as of the earliest date of the crime.

Q. Work Life Balance Stipend: CalOptima Health shall provide an annual Work Life Balance Stipend of five hundred dollars ($500.00) to Full-Time Employees and two hundred fifty dollars ($250.00) to Part-Time Employees. The stipend is intended to promote employee wellness through enhanced work life balance and may be used for any wellness-related purchases, such as dependent care, gym memberships, yoga classes, art therapy, dietician services, athletic gear, personal development courses, and more. The stipend is taxable and paid in two (2) increments of two hundred fifty dollars ($250.00) to Full-Time Employees and one hundred twenty-five dollars ($125.00) to Part-Time Employees on the pay periods that include November 01, and May 01 each year.

R. Benefit Income: CalOptima Health shall provide a bi-monthly taxable medical stipend as a cost savings measure to CalOptima Health and incentive for employees who have medical coverage outside of CalOptima Health. Employees must submit proof of outside coverage in order to be eligible for this benefit. The amount of the bi-monthly stipend is approved by the Board of Directors on an annual basis.

S. TUP: An employee who is appointed for a limited duration to a job having a higher pay grade is eligible for TUP. The employee must meet the minimum requirements of the position and be performing all essential job functions and responsibilities of the upgraded position without performing duties of their current job to qualify for TUP. TUP will be the minimum of the new pay rate or a five percent (5%) of the base pay increase, whichever is greater. TUP will be eliminated

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when the temporary assignment ends and incumbent will return to their previous pay grade. The temporary assignment shall not exceed nine hundred and sixty (960) hours. TUP is considered premium pay pursuant to Title 2 CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS Classic Members only.

T. TAP: At the discretion of the CEO, an employee assigned higher-level duties for a limited duration may receive TAP either (1) as supplemental pay in addition to TUP when the TUP amount calculated under Section II.S does not provide compensation appropriate for the temporary assignment, or (2) as an alternative to TUP when the employee does not satisfy the eligibility requirements for TUP or when the CEO determines that an alternative compensation approach is appropriate. TAP will be based on the employee's qualifications, internal pay practices, and other relevant business considerations. When TAP is paid in addition to TUP, TAP will equal the difference between the employee's pay rate after application of TUP and the total temporary pay rate approved by the CEO. In all cases, the employee's total temporary pay rate may not exceed the maximum rate of the pay grade for the higher-level position or assignment. TAP will end when the temporary assignment or higher-level duties end. TAP is not considered Special Compensation for CalPERS reporting.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima Health observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not eligible for Holiday Premium Pay and will be paid at the employee's regular base pay. Actual hours worked on a holiday will be used for purposes of calculating overtime.

C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal language fluency evaluation when bilingual proficiency is a required part of the employee's or potential employee's job and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, bilingual pay shall be established. For new hires, the Bilingual Pay begins with the first pay period of their employment. Changes to Bilingual Pay will occur at the start of a pay period. Bilingual pay shall not be prorated. Temporary and/or interim assignments will not impact bilingual pay.

D. Night Shift Differential:

1. Night Shift Differential is automatically calculated for those employees regularly working a night shift.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting to make up time or work alternative hours, and as a result, would be eligible for night shift differential pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

E. On Call Accessible and On Call Working Pay:

1. If employees are on call or get called back to work, the employees are responsible for adding this time to their schedules through CalOptima Health's time keeping system, which is then approved by their supervisors.

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F. Commuter Allowance:

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima Health may periodically audit and validate employee Office/Telework designations.

G. Internet Stipend:

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima Health may periodically audit and validate employee Office/Telework designations.

H. Certified Case Manager Pay (CCM):

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department. Temporary and/or interim assignments will not impact CCM pay.

I. Executive Incentive Plan:

1. The Board of Directors approves CalOptima Health's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Level Positions. CalOptima Health's Executive Incentive Pay Plan will be administered in accordance with the CalOptima Health Executive Incentive Plan Guidelines.

J. Employee Sales and Enrollment Incentive Program:

1. The Executive Director, Medicare Programs or designee will review the Employee Sales and Enrollment Incentive structure for the OneCare, PACE, Covered California Programs on at least an annual basis and will submit any required changes to the incentive structure and the OneCare, PACE, and Covered California Employee Sales and Enrollment Incentive Agreements for review and approval by the CEO, or designee.

2. OneCare:

a. Employees eligible for the Sales and Enrollment Incentive Program will be required to sign a OneCare Sales and Enrollment Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific each eligible employee job title.

b. The OneCare Director will be responsible for calculating monthly payments for employees who are eligible for the OneCare Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the OneCare Sales and Enrollment Incentive Agreement effective at the time the enrollments are produced. The Director will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

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3. PACE:

   a. PACE Employees eligible for the Sales and Enrollment Incentive Program will be required to sign a PACE Sales Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

   b. The PACE Manager Marketing & Enrollment will be responsible for calculating monthly incentive payments for employees who are eligible for the PACE Sales and Enrollment Incentive Program based on the number of enrollments produced each month according to the terms of the PACE Sales and Enrollment Incentive Program Agreement effective at the time the enrollments are produced. The Manager will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

4. Covered California:

   a. Employees eligible for the Covered California Incentive Program will be required to sign a Covered California Incentive Agreement on an annual basis, which may include revisions to the incentive structure or enrollment goals specific to their job title.

   b. The Director Operations Management will be responsible for calculating monthly incentive payments for employees who are eligible for the Covered California Incentive Program based on the number of enrollments produced each month according to the terms of the Covered California Incentive Program Agreement effective at the time the enrollments are produced. The Director will submit a detailed report of enrollments produced and payments due for approval by the Executive Director, Medicare Programs, and the Chief Financial Officer.

K. CalRecognition Award: As circumstances warrant, any leader who observed another employee demonstrating exceptional CARES values in the workplace may nominate that individual for this incentive. The nomination is sent by email with a supporting description of the achievement through the employee's department's reporting structure. The area Chief may provide the final nomination to the CEO. The CEO makes the final approval if any and determines the incentive amount. If approved by the CEO, the incentive is processed into payroll, and the certificate is prepared by Human Resources for the issuing department leader.

L. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period.

M. Sign-on Incentive: As circumstances warrant, the CEO may offer a sign-on incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima Health. To receive the sign-on incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a sign-on incentive to return the full amount of the sign-on incentive if the recipient voluntarily terminates employment with CalOptima Health within twenty-four (24) months of the date of hire.

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N. Service Award: Employees earn years of service credit toward this award through each complete year of employment with CalOptima Health. Service years do not have to be consecutive for purposes of Service Award. At the discretion of the CEO, Service Awards are issued annually to eligible employees to celebrate their long-term commitment to the agency and our members.

O. Merit Lump Sum Bonus: Once employees have reached the pay range maximum, employees may be eligible for merit Bonus Pay delivered as a lump sum bonus, provided that their annual performance evaluations meet the established goals and objectives set forth by their managers. Merit Bonus Pay will not exceed the maximum percentage of the merit increase matrix and reflects employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima Health to be eligible to earn and receive the lump sum bonus payments.

P. Automobile Allowance: As circumstances warrant, the CEO may offer employees in Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the employees' W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the employee must comply with the following requirements:

1. Maintain adequate levels of personal vehicle insurance coverage;

2. Purchase their own fuel for the vehicle; and

3. Ensure the vehicle is properly maintained.

Q. Work Life Balance Stipend: Work Life Balance Stipend is automatically calculated for eligible employees. To be eligible, employees must be in active status (either working or on a paid LOA) in the pay period that includes May 1 or November 1. Employees on an approved, unpaid LOA when the Work Life Balance Stipend is paid will receive a retroactive payment upon return to active status.

R. Benefit Income: Once enrolled in Benefit Income, the participating employee's election to waive CalOptima Health medical insurance will remain in effect for the entire, or remaining, plan year (January 1 through December 31) unless the employee has a qualifying event. Benefit Income may be temporarily suspended for employees who are on an approved Leave of Absence (LOA) without pay in accordance with CalOptima Health Policies GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation, GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, GA.8041: Workers' Compensation Program, or GA.8063: Disability Accommodations. However, retroactive payment for Benefit Income will be applied for the period of protected, unpaid leave upon return to active duty.

S. TUP: Human Resources will calculate TUP for eligible employees who are authorized and appointed for a limited duration to assume the duties of a position with a higher pay grade.

T. TAP: As circumstances warrant, the CEO may approve TAP, including whether it will be paid in addition to TUP or as an alternative to TUP and the approved total temporary pay rate. Human Resources will determine and document eligibility, calculate the TAP amount, confirm that the employee's total temporary pay rate does not exceed the applicable pay-grade maximum, and provide the approved amounts and effective dates to Payroll. Human Resources will review any change in the assignment that may affect eligibility or the approved amount. TAP will be discontinued when the approved temporary assignment or higher-level duties end.

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U. Supplemental Compensation During Leave of Absence: An employee on a Continuous LOA is not eligible to receive certain supplemental compensation, such as Bilingual Pay, Night Shift Differential, On Call Pay, Certified Case Manager Pay (CCM), Internet Stipend, Commuter Allowance, or Automobile Allowance during their LOA. If applicable, an employee on a Continuous LOA may be eligible for Employer-Paid Member Contribution, Supplemental Retirement Benefit and Benefit Income during any portion of a paid LOA but shall not be eligible if the LOA is unpaid. Executive incentives will be prorated to account for an executive's Personal LOA time period. Executives must be current employees during the pay period the executive incentive is paid for eligibility. Supplemental compensation will resume when the employee returns to an active status, and may be prorated, where applicable.

V. Proration: For supplemental compensation that is paid per pay period and not based on hourly pay rate (i.e. Bilingual Pay, Active Certified Case Manager, Internet Stipend, Commuter Allowance, Automobile Allowance, and Benefit Income), such compensation will begin the first Full Pay Period after eligibility is established. These items of compensation will be provided only for Full Pay Periods and will not be prorated for a change in eligibility for a portion of the pay period.

W. Supplemental Compensation for Part-Time Employees

1. If eligible, regular Part-Time Employees will receive pro-rated supplemental compensation based on their approved work schedule, as reflected in the timekeeping system, for the following:

    a. Certified Case Manager Pay (CCM) / Educational Incentive;

    b. Executive Incentive Pay Plan;

    c. Merit Lump Sum Bonus;

    d. Automobile Allowance; and

    e. Benefit Income.

2. Exceptions include the following:

    a. Bilingual Pay, Internet Stipend and Work Life Balance Stipends will be paid in accordance with Section II.

X. Part-Time Employees are not eligible for the Commuter Allowance.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. CalOptima Health Executive Incentive Plan Guidelines
C. CalOptima Health Performance Review of Executives Template
D. CalOptima Health Policy GA.8039: Pregnancy Disability Leave and Related Workplace Accommodation

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E. CalOptima Health Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Program
G. CalOptima Health Policy GA.8056: Paid Holidays
H. CalOptima Health Policy GA.8063: Disability Accommodations
I. Compensation Administration Guidelines
J. Covered California Sales and Enrollment Incentive Program Agreements
K. Government Code, §20636 and 20636.1
L. OneCare Sales and Enrollment Incentive Program Agreements
M. PACE Sales and Enrollment Incentive Program Agreements
N. Telework Program Guidelines
O. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
05/04/2023	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors
06/04/2026	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative
Revised	06/02/2022	GA.8042	Supplemental Compensation	Administrative
Revised	05/04/2023	GA.8042	Supplemental Compensation	Administrative
Revised	12/07/2023	GA.8042	Supplemental Compensation	Administrative
Revised	06/06/2024	GA.8042	Supplemental Compensation	Administrative
Revised	06/05/2025	GA.8042	Supplemental Compensation	Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2026	GA.8042	Supplemental Compensation	Administrative
Revised		GA.8042	Supplemental Compensation	Administrative

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IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima Health's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by the Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima Health's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by the C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Community Worker	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Continuous Leave of Absence (LOA)	Leave that is taken uninterruptedly, rather than intermittently.
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Pay Period	A Full Pay Period refers to all of an employee's scheduled work hours within a pay period.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Full-Time Employees	For purposes of this policy, employees who are regularly scheduled to work thirty (30) hours or more per week.
Leave of Absence (LOA)	A term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.

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Term	Definition
Night Shift	Regularly scheduled shifts with start time between 3 p.m. and 11 p.m.
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Part-Time Employees	Employees who are regularly scheduled to work less than thirty (30) hours per week.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare, PACE, or Covered California Programs.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	A threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

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Policy:	GA.8065
Title:	**Paid Time Off (PTO) Donation Policy**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	
Revised Date:	
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

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I. PURPOSE

This policy establishes the CalOptima Health PTO Donation Program, which allows eligible employees to voluntarily donate a portion of their accrued PTO to another employee who is experiencing a qualifying Catastrophic Illness or Injury, or who is caring for a Qualifying Family Member with a catastrophic illness or injury. The primary objective of this program is to provide temporary financial support during an approved medical absence when the recipient employee has exhausted all available employer paid leave.

Allocations from this program are designed to provide income replacement during periods of unpaid leave, or to supplement partial third-party wage replacement benefits (such as Short-Term Disability) to 100% of the employee's regular base wages. Participation in this program is completely voluntary, and CalOptima Health reserves the right to amend, alter, or terminate this policy at any time, at the sole direction of the Human Resources Department.

II. POLICY

A. Participation in the PTO Donation Program is voluntary.

B. Recipient Eligibility

1. Have a medically verified Catastrophic Illness or Injury or be caring for a Qualifying Family Member with such a condition that requires a Prolonged Absence.

2. Have worked for CalOptima Health for at least ninety (90) days and be eligible to accrue PTO under the applicable policy.

3. Be in active employment status and on an approved Leave of Absence (LOA) consistent with CalOptima Health LOA policies.

4. Have reached exhaustion of all paid leave available, including accrued PTO, Flex Holiday, and other applicable paid leave balances.

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5. Submit completed PTO donation request and authorization form, including required medical certification prior to the exhaustion of their accrued PTO (or within fifteen (15) calendar days from the beginning of their leave if PTO is exhausted prior to leave).

C. Recipient Limits

1. For employees eligible to receive Short-Term Disability (STD) benefits or other third-party wage replacement benefits, the maximum allocation of donated PTO is limited to the amount necessary to bridge the gap between the disability benefit and 100% of the recipient's regular base wages. Under no circumstances will the combination of third-party disability payments and donated PTO allocations exceed 100% of the employee's normal gross weekly wages.

2. For employees not eligible for third-party disability benefits, the maximum allocation of donated PTO shall not exceed 100% of the employee's regular base wages.

3. Employees may request PTO donations no more than once within any rolling twelve (12)-month period, measured from the date the employee first uses donated PTO from their previously approved request.

D. Donor Eligibility and Authorizations

1. Donate a minimum of one (1) hour, in whole-hour increments.

2. Maintain a minimum balance of one hundred (100) accrued PTO hours after the donation is processed.

3. Submit a signed donation form authorizing the transfer and acknowledging that, once processed and transferred, donations are irrevocable.

4. Donors will remain anonymous.

E. Tax Treatment

1. Donated PTO is considered taxable income to the recipient; applicable taxes will be withheld per standard payroll practices.

2. Donors realize no taxable income and face no payroll tax withholdings upon surrendering their hours.

F. Processing Rules

1. Upon approval of application, the Human Resources Department will issue an organization wide notification announcing an opportunity to donate PTO. PTO donations will only be accepted while the recipient remains on paid status. Once the recipient enters an unpaid status, no further PTO donations will be accepted.

2. Donation forms will be processed in the order received.

3. Donated PTO hours are first converted into a dollar value using the donor's regular hourly rate at the time of conversion. That dollar value is then converted into PTO hours for the recipient, using the recipient's regular hourly rate. Example: If a donor earning $25.00 per hour donates eight (8) hours ($200.00), and the recipient earns $20.00 per hour, the recipient receives ten (10) hours of PTO.

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4. The PTO hours from the first donor employee will be converted and applied to the recipient employee's PTO bank for the first payroll period in which donated hours are needed.

5. The second donor employee's PTO will only be applied once the first donor's submitted hours are fully exhausted. This second donation may be utilized within the same pay period or carried forward to the next payroll period if the previous donation satisfied the full income gap.

6. All subsequent donor forms will follow this chronological pattern. If any donation forms remain at the end of the employee's leave, the unprocessed hours will be returned to the donor.

7. The amount available to an eligible recipient will be determined by Human Resources based on:

    a. The employee's regular gross compensation;

    b. Eligible wage replacement benefits received by the employee;

    c. The employee's approved leave period;

    d. The number of donated hours received; and

    e. Any applicable limits under this policy.

8. All donations are subject to Human Resources Department review for compliance with this policy.

III. PROCEDURE

Responsible Party	Action
Recipient Employee	Request a Leave of Absence; submit a completed donation request and authorization with supporting medical documentation to the Human Resources Department.
Human Resources Department	Review requests for completeness and eligibility; within ten (10) days of receiving all materials, notify the employee of approval or rejection; if approved, coordinate donation processing, converting donated hours to dollars at recipient's rate.
Donor Employee	Submit donation authorization specifying whole hours to donate; acknowledge that once processed and transferred, donations are irrevocable.

IV. ATTACHMENT(S)

Not applicable

V. REFERENCE(S)

A. CalOptima Health Employee Handbook
B. CalOptima Health Policy GA.8037: Leave of Absence
C. CalOptima Health Policy GA.8038: Personal Leave of Absence
D. CalOptima Health Policy GA.8040: FMLA and CFRA Leaves of Absence

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E. CalOptima Health Policy GA.8041: Workers' Compensation Program
F. CalOptima Health Policy GA.8059: Attendance and Timekeeping
G. Title 26, Code of Federal Regulations (C.F.R.) § 1.451-2 et seq. (Constructive Receipt of Income)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective		GA.8065	Paid Time Off (PTO) Donation Policy	Administrative

For 20261105BODReviewOnly

IX. GLOSSARY

Term	Definition
Catastrophic Illness or Injury	A medically verified, life threatening or debilitating illness, injury or condition which is monumental, unusual, unexpected, immediate in nature, and expected to preclude the employee from returning to work for an extended period of time.
Qualifying Family Member	Under the PTO Donation Program, qualifying family members include Spouse or Registered Domestic Partner, Child, or Parent.
Prolonged Absence	For the purposes of this policy, a prolonged absence is one that incapacitates the employee or their family member for at least twenty-one (21) consecutive calendar days. May include intermittent absences that are related to the same illness, injury or condition.

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FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Date Last Updated: **10/20/2026**

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CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - September 2026

Goal	3-Year Performance Metric	Owner	Actual	3-Year Target
1.1	Glycemic Status Assessment for Patients With Diabetes (GSD) - Medi-Cal	Kelly Giardina	**41.40%**	**27.98%**
1.1	Glycemic Status Assessment for Patients With Diabetes (GSD) - OneCare	Kelly Giardina	**61%**	**92%**
1.2	Percentage of members successfully enrolled in Complex Case Management	Kelly Giardina	**0.04%**	**0.04%**
1.3	Initial Health Appointment (IHA) Completion Rate - Medi-Cal	Kelly Giardina	**33%**	**40%**
1.3	Annual Wellness Visit (AWV) Completion Rate - OneCare	Kelly Giardina	**39%**	**70%**
1.4	Number of Community-Based Organizations (CBOs) participating in prevention campaigns and quality care gap closures	Marie Jeannis	**33**	**10**
2.1	Medi-Cal Star Rating	Linda Lee	**4.0**	**4.0**
2.1	Medicare Star Rating	Linda Lee	**3.5**	**3.5**
2.2	Quarterly count of grievances related to Access and Availability	Michael Gomez	**854**	**640**
2.3	Overall provider satisfaction rate	Michael Gomez	**TBD**	**70%**
2.4	Percentage of Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days	Carmen Katsarov	**33th**	**50th**
3.1	Number of members served through Street Medicine	Dr. Kelly Bruno-Nelson	**1,337**	**750**
3.2	Number of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions	Marie Jeannis	**1,830**	**250**
3.3	Percentage of net income allocated to community investments in health equity, prevention, and access to care	Donna Laverdiere	**34.3%**	**7.5%**
3.4	Percentage of grant agreements on track and in compliance with program objectives and budget expenditures	Dr. Kelly Bruno-Nelson	**94%**	**90%**

Goal	3-Year Performance Metric	Owner	Actual	3-Year Target
4.1	Treatment authorization processing time (business days) for all providers (Routine)	Kelly Giardina	**1.30**	**1.63**
4.1	Treatment authorization processing time (business days) for all providers (Urgent)	Kelly Giardina	**0.35**	**0.61**
4.2	Claims auto-adjudication rate - Medi-Cal	Ladan Khamseh	**86%**	**84%**
4.2	Claims auto-adjudication rate - OneCare	Ladan Khamseh	**75%**	**76%**
4.3	Membership growth by Line of Business - OneCare	Javier Sanchez	**19,148**	**30,000**
4.3	Membership growth by Line of Business - PACE	Javier Sanchez	**602**	**700**
4.3	Membership growth by Line of Business - Covered CA	Donna Laverdiere	**TBD**	**20,000**
4.4	Voluntary Disenrollment rate	Javier Sanchez	**7.53%**	**5.00%**
4.5	Percentage of Digital Transformation projects completed on time and within budget	Kathleen Linder	**84%**	**95%**
4.6	CAHPS Rating of Health Plan	Ladan Khamseh	**3.0**	**4.0**
4.7	Quarterly Administrative Loss Ratio measure	Nancy Huang	**5.6%**	**7.0%**
4.8	Percentage of open positions filled by qualified internal candidates	Steve Eckberg	**49%**	**50%**

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CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - September 2026

1.0 Equity and Population Health

CalOptima Health will infuse the pursuit of health equity throughout our work and will continue to innovate and develop tools and interventions that advance the physical, behavioral, and social health of our members.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	Glycemic Status Assessment for Patients With Diabetes (GSD) - Medi-Cal	Kelly Giardina	•Ongoing collaboration with Health Networks for member outreach. Board approved new Diabetes Management Program Policy. •Multilingual text outreach to members to encourage diabetes testing. •Held member screening and education events for blood pressure and A1c in June and September 2026. •The GSD measure typically starts low early in the year and rises over time as more members complete A1c screenings within the target range.	41.40%	27.98%	• Target based on 66th percentile. This metric was revised in December 2025 to ensure alignment with appropriate diabetes measure. • Inverse Measure (Lower is Better)
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	Glycemic Status Assessment for Patients With Diabetes (GSD) - OneCare	Kelly Giardina	•Ongoing collaboration with Health Networks for member outreach. Board approved new Diabetes Management Program Policy. •Launched OC TeleMed2U endocrinology telehealth pilot for diabetic members. •Multilingual text outreach to members to encourage diabetes testing. •Held member events for blood pressure and A1c in June and September. •The GSD measure starts low early in the year and rises over time as more members complete A1c screenings within	61%	92%	• Target based on 5-Stars. This metric was revised in December 2025 to ensure alignment with appropriate diabetes measure.
1.2 Implement a consistent model of care for population health/care management, including delegated networks.	Percentage of members successfully enrolled in Complex Case Management	Kelly Giardina	•Regularly review and oversee Complex Case Management (CCM) enrollment numbers in Health Network Joint Operation meetings. •Met with Astrana Health to advance CCM enrollment and referral strategy. •Set expectations and progress toward targets in Health Network Oversight meetings.	0.04%	0.04%	• .05% = approximately 400 members. Targets set at 0.03% in year 1, 0.04% in year 2, and 0.05% in year 3.
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Initial Health Appointment (IHA) Completion Rate - Medi-Cal	Kelly Giardina	•Monitoring utilization of PCP and finding decline in Initial Health Appointment (IHA) aligns with utilization trend. •Updated auto-assignment process to reduce the timeframe for members to be assigned to Health Network and PCP, effective July 1. •Joined a multi plan IHA workgroup to align on best practices. •Expanding data input through IHA measure in Cozeva, effective January 1, 2027. •Monthly text campaigns for IHA continues.	33%	40%	
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Annual Wellness Visit (AWV) Completion Rate - OneCare	Kelly Giardina	•Monitoring utilization of PCP and finding decline in Annual Wellness Visit (AWV) aligns with utilization trend. •Updated auto-assignment process to reduce the timeframe for members to be assigned to Health Network and PCP, effective July 1. •Joined a multi plan IHA workgroup to align on best practices. •Expanding data input through IHA measure in Cozeva, effective January 1, 2027. •Monthly text campaigns for AWV continues.	39%	70%	
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.	Number of Community-Based Organizations (CBOs) participating in prevention campaigns and quality care gap closures	Marie Jeannis	•Collaborated with Boys and Girls Club Garden Grove (BGCGG) on HPV prevention content; launched digital ads in cities with greatest child well-care needs. •Published 3 newspaper ads with BGCGG HPV prevention content targeting communities with high membership and lower vaccination rates. •Partnered with Health Equity for African Americans League (HEAAL) to promote children's flu vaccination and to gather community feedback on a prostate cancer prevention flyer at 9/2026 BIPOC Health Fair in Santa Ana.	33	10	

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CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - September 2026

2.0 Quality and Value

CalOptima Health is committed to providing the highest quality physical, behavioral, and social health care to our members and to ensuring sound stewardship of public dollars by achieving greater value.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Medi-Cal Star Rating	Linda Lee	•Achieved NCQA Medi-Cal Health Plan rating of 4.0 stars. •Improved from 3.5 stars in prior year.	**4.0**	**4.0**	
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Medicare Star Rating	Linda Lee	•Achieved Medicare Overall Star Rating of 3.5. •Improved from prior year overall Star rating of 3.0. •Achieved 1 full star improvement for both Part C and Part D star ratings.	**3.5**	**3.5**	
2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.	Quarterly count of grievances related to Access and Availability	Michael Gomez	•Network Adequacy Executive Workgroup defining project charter •Development of additional data analysis required to identify root cause of delays in care when there is a sufficient number of providers within a specialty/zip code	**854**	**640**	• Inverse Measure (Lower is Better)
2.3 Increase provider engagement through improved provider tools, data exchange, and collaboration.	Overall provider satisfaction rate	Michael Gomez	•Launched 100-day Rx supply, members with elevated A1C and additional trainings in the Provider Portal •2026 Provider Satisfaction Survey vendor secured •Uploaded the P4V Manual to the Provider Portal •Provider Relations educating Provider offices on Gaps in Care reports within the Portal •Cozeva roll-out continues with positive provider feedback	**TBD**	**70%**	• New Measure - no data available at this time
2.4 Expand the delivery of Behavioral Health services, invest in the workforce, and drive quality improvement through innovation.	Percentage of Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days	Carmen Katsarov	•TELEMED2U completed over 7,600 visits from July through Sept 2026 (year 3 of contract). •Follow Up After Emergency Room for mental illness (FUM) 30 day Prospective rate had a 0.03% increase from July (40.53%) to Aug(40.56%). •Prospective rate for FUM 30-day increased by 1.46 % from measurement year (MY)2025 Q3 (August) to MY2026 Q3 (August). •Over $1.5 million paid out to school districts by CalOptima Health for mental health services through DHCS school fee schedule.	**33th**	**50th**	• Percentile based HEDIS benchmarks

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FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - September 2026

3.0 Community Partnerships and Investments

CalOptima Health will continue to demonstrate our partnership with Orange County members, providers, county agencies, and community organizations through Medi-Cal Transformation programs and robust community investments and partnerships to advance health equity.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
3.1 Expand social support services through Medi-Cal Transformation and other social health initiatives.	Number of members served through Street Medicine	Dr. Kelly Bruno-Nelson	•97% of enrolled members have an active relationship with their Primary Care Physician. •68 members have been permanently housed. •84% of the enrolled members have been screened for hypertension. •In August 2026, 68% of enrolled members who went to the Emergency Department had a follow up medical visit within 30 days of discharge.	**1,337**	**750**	
3.2 Expand community involvement in co-creation of solutions that best serve members.	Number of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions	Marie Jeannis	•Engaged 83 individuals from 33 organizations at the August Health Equity Community Stakeholder Workgroup (HECSW). Prioritized actions related to state and federal budgetary and policy changes. •Partnered with five community organization representatives to co-design facilitation for HECSW meetings. •Met with nine individuals across seven FQHC stakeholder meetings to assess mobile unit services and preventive care opportunities. •Presented Medi-Cal updates to 65 Tustin Unified School District (TUSD) Student Services staff and 95 Behavioral Health Equity Committee Summit attendees.	**1,830**	**250**	
3.3 Prioritize community investments that advance health equity, drive prevention, and improve access to care.	Percentage of net income allocated to community investments in health equity, prevention, and access to care	Donna Laverdiere	•Ongoing monitoring of board-approved initiatives. •Completed release of Member and Population Health Needs Assessment report; findings and recommendation shared with the Board in August. •Funding Priorities Framework was presented to the Board in October.	**34.3%**	**7.5%**	
3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.	Percentage of grant agreements on track and in compliance with program objectives and budget expenditures	Dr. Kelly Bruno-Nelson	•Awarded grants through the Housing and Homelessness Incentive Program Round 6 Notice Of Funding Opportunity (NOFO) in September 2026. •Accepting applications from cities for the City Health Improvement Grant NOFO. •Accepting applications for the Quality Improvement Grant Program MY2024 Round 2. •Developing a NOFO for the Community Enrollers Academy to be released in December 2026.	**94%**	**90%**	

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4.0 Operations, Finance and People

CalOptima Health's continued investment in our performance and people are vital to ensuring the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Treatment authorization processing time (business days) for all providers (Routine)	Kelly Giardina	•Collaborated with Medical Directors to enhance nurse process for improved efficiency through revised protocols and expanded Medical Authorization Assistant (MAA) responsibilities. •Launched Letter of Agreement (LOA)/Out-of-Network (OON) workgroup and established protocols to review OON requests for diversion in-network. •Initiated MAA education to support the Nurses in their review process.	**1.30**	**1.63**	• Inverse Measure (Lower is Better)
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Treatment authorization processing time (business days) for all providers (Urgent)	Kelly Giardina	•Collaborated with Medical Directors to enhance nurse process for improved efficiency through revised protocols and expanded Medical Authorization Assistant (MAA) responsibilities. •Launched Letter of Agreement (LOA)/Out-of-Network (OON) workgroup and established protocols to review OON requests for diversion in-network. •Initiated MAA education to support the Nurses in their review process.	**0.35**	**0.61**	• Inverse Measure (Lower is Better)
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Claims auto-adjudication rate - Medi-Cal	Ladan Khamseh	•As of September 2026, rate remains steady at 86% as claims and IT teams continue to automate manual processes using logic enhancements in Facets.	**86%**	**84%**	
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Claims auto-adjudication rate - OneCare	Ladan Khamseh	•As of September 2026, rate is at 75% as Claims and IT teams continue to automate manual processes using logic enhancements in Facets.	**75%**	**76%**	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - OneCare	Javier Sanchez	•Trending slightly slower than anticipated, however onboarded new Field Marketing Organization (FMO) to help generate greater sales. •Increase in total number of broker agencies and brokers selling product will support greater volume.	**19,148**	**30,000**	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - PACE	Javier Sanchez	•PACE Garden Grove: Enrollment census reached 602 members as of June (max capacity: 625); 23 spots remain, with capacity expected to be reached in ~3-4 months at the current growth rate. •PACE continues to work towards the second location. Expected to Open 2027/2028. •PACE is working on ACS expansion to a new partner to join Q12027.	**602**	**700**	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - Covered CA	Donna Laverdiere	•Conducted onsite readiness training for leadership and staff •Qualified Health Plan issuer contract approved by Covered California. •Participated in state CalHEERS eligibility testing with successful results. •Operational readiness activities continue – on track for Open Enrollment on November 1, 2026	**TBD**	**20,000**	• New Measure - no data available at this time

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4.0 Operations, Finance and People

CalOptima Health's continued investment in our performance and people are vital to ensuring the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
4.4 Optimize the Medicare line of business to improve the member retention rate and support growth.	Voluntary Disenrollment rate	Javier Sanchez	•Year-to-Date disenrollment as of September 26 is trending higher than goal. •Retention team transition initiated and process development underway.	**7.53%**	**5.00%**	• Overall target is <5% for each calendar year end • Inverse Measure (Lower is Better)
4.5 Implement the comprehensive Digital Transformation strategic roadmap to improve member experience and efficiency.	Percentage of Digital Transformation projects completed on time and within budget	Kathleen Linder	•On track for 95% completion by July 1, 2027. •Credentialing: RFP completed, and kick-off will occur in early 2027 (go live is TBD in 2027). •Prior-Authorization Interoperability: On track for 1/1/2027 go live.	**84%**	**95%**	• Rolling data based on project completion
4.6 Optimize member engagement functions to improve member retention, satisfaction, and outcomes.	CAHPS Rating of Health Plan	Ladan Khamseh	•Customer Service: After call Survey Q3 Overall Satisfaction rate: 93.6%; Completed Responses: 689 Surveys Distributed: 2,148 response rate: 32%. •Q3 Voluntary Disenrollment: Surveys attempted: 510; Completed Surveys: 98; Response Rate: 19%; Members that changed their mind and stayed with OneCare: 39.	**3.0**	**4.0**	
4.7 Ensure fiscal accountability and stewardship, including a balanced operating budget, quarterly budget reconciliation, and vendor and provider contracting.	Quarterly Administrative Loss Ratio measure	Nancy Huang	•Our ALR is at 3.7%, however, excluding Hospital DP which is a pass through payment, we are at 5.6%.	**5.6%**	**7.0%**	• Inverse Measure (Lower is Better)
4.8 Launch expanded employee development and retention efforts to drive employee engagement and advancement.	Percentage of open positions filled by qualified internal candidates	Steve Eckberg	•HR strategic plan for FY27 includes two focus areas to increase the pool of internal qualified candidates: development and retention. •Employee development programs equip current staff with skills needed for future roles or advancement. •Increasing awareness of the value of CalOptima Health employment to minimize voluntary turnover. •Over the past rolling 12 months, 48.95% of the hires were internal.	**49%**	**50%**	

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Financial Summary
September 30, 2026

Board of Directors Meeting

November 5, 2026

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Financial Highlights Notes: September 2026

- $612.7 million of Calendar Year (CY) 2024 Phase 2 and 2025 Phase 1 Hospital Directed Payments (DP) received and recognized in Capitation Revenue in September 2026. Associated provider payments were also remitted in September 2026 and included in Other Medical Expenses.
- September 2026 financials reflected a true-up to the final CY 2025 Medi-Cal capitation rates from the Department of Health Care Services (DHCS), offset by claim adjustments from prior periods, resulting in a net positive change of $8.8 million in Net Assets.
- Negative Investment Income reflects unrealized loss in market value driven by rising interest rates. Management expects investment performance to normalize as market conditions stabilize.

CalOptima Health

Financial Highlights
September 2026

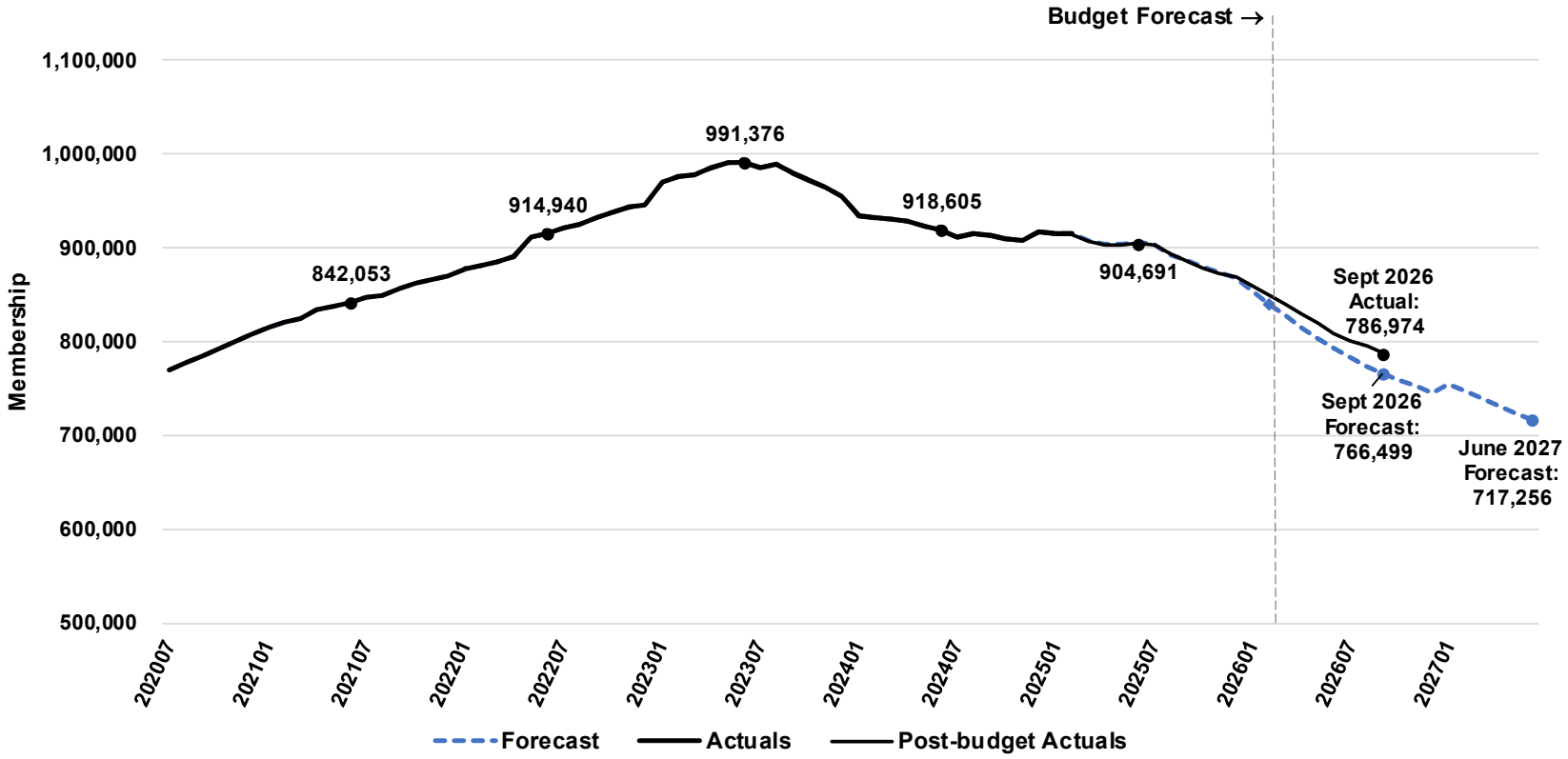
September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
788,667	766,499	22,168	2.9%	Member Months	2,384,838	2,322,475	62,363	2.7%
1,029,431,604	368,664,341	660,767,263	179.2%	Revenues	1,793,156,336	1,115,592,105	677,564,231	60.7%
996,414,869	352,570,986	(643,843,883)	(182.6%)	Medical Expenses[1]	1,725,862,138	1,076,620,460	(649,241,678)	(60.3%)
22,127,773	25,303,644	3,175,871	12.6%	Administrative Expenses	65,826,781	76,047,803	10,221,022	13.4%
10,888,962	(9,210,289)	**20,099,251**	**218.2%**	**Operating Margin**	**1,467,417**	(37,076,158)	**38,543,575**	**104.0%**
				Non-Operating Income (Loss)				
(9,073,869)	8,333,330	(17,407,199)	(208.9%)	Net Investment Income/Expense	10,873,745	24,999,990	(14,126,245)	(56.5%)
(1,669,584)	-	(1,669,584)	(100.0%)	Grant Expense	(2,964,491)	-	(2,964,491)	(100.0%)
1,150,050	-	1,150,050	100.0%	Community Reinvestment	1,944,162	-	1,944,162	100.0%
1,186,145	(172,007)	1,358,152	789.6%	Other Income/Expense	879,106	(516,021)	1,395,127	270.4%
(8,407,258)	**8,161,323**	(16,568,581)	(203.0%)	**Total Non-Operating Income (Loss)**	**10,732,522**	**24,483,969**	(13,751,447)	(56.2%)
2,481,704	(1,048,966)	**3,530,670**	**336.6%**	**Change in Net Assets**	**12,199,939**	(12,592,189)	**24,792,128**	**196.9%**
96.8%	*95.6%*	*1.2%*		*Medical Loss Ratio*	*96.2%*	*96.5%*	(0.3%)	
2.1%	*6.9%*	*4.7%*		*Administrative Loss Ratio*	*3.7%*	*6.8%*	*3.1%*	
1.1%	(2.5%)	*3.6%*		*Operating Margin Ratio*	*0.1%*	(3.3%)	*3.4%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		

[1]Actual Medical Expenses include the Board-approved Provider Rate Increases

CalOptima Health

Actuals v. Budget – Total Membership

Consolidated



Notes:

- Data included in this report are based on member eligibility months rather than booked enrollment (as used in the financials)
- Includes data as of October 9, 2026

CalOptima Health

FY 2026-27: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) September 2026: $2.5 million, favorable to budget $3.5 million or 336.6% driven by favorable enrollment and timing of administrative expense activities, offset by unfavorable claim expenses and net investment loss
  - Year To Date (YTD) July – September 2026: $12.2 million, favorable to budget $24.8 million or 196.9% driven by favorable enrollment and timing of administrative expense activities, offset by unfavorable claim expenses and net investment loss

CalOptima Health

FY 2026-27: Management Summary (cont.)

- Enrollment
  - MTD: 788,667 members, favorable to budget 22,168 or 2.9% due to lower-than-expected disenrollment from federal and state policy changes and eligibility redetermination
  - YTD: 2,384,838 members, favorable to budget 62,363 or 2.7% due to lower-than-expected disenrollment from federal and state policy changes and eligibility redetermination

CalOptima Health

FY 2026-27: Management Summary (cont.)

- Revenue
  - MTD: $1,029.4 million, favorable to budget $660.8 million or 179.2% due to:
    - $9.8 million favorable volume variance to budget in MC LOB due to higher than projected enrollment
    - $649.0 million favorable price variance to budget in MC LOB due primarily to CY 2024 and 2025 Hospital DP
  - YTD: $1,793.2 million, favorable to budget $677.6 million or 60.7% due to:
    - $27.6 million favorable volume variance to budget in MC LOB due to higher than projected enrollment
    - $650.3 million favorable price variance to budget in MC LOB due primarily to CY 2024 and 2025 Hospital DP

CalOptima Health

FY 2026-27: Management Summary (cont.)

- Medical Expenses
  - MTD: $996.4 million, unfavorable to budget $643.8 million or 182.6% due to:
    - $612.5 million unfavorable variance in Other Medical Expenses due primarily to CY 2024 and 2025 Medi-Cal Hospital DP
    - $24.4 million unfavorable variance in Professional Claims due to increase in utilization mental health, Community Supports and adjustments relating to prior period Medi-Cal claims
    - $3.8 million unfavorable variance in Prescription Drugs due to adjustments to OneCare (OC) rebates
    - $3.1 million unfavorable variance in all other expense categories (net)

CalOptima Health

FY 2026-27: Management Summary (cont.)

- Medical Expenses (cont.)
  - YTD: $1,725.9 million, unfavorable to budget $649.2 million or 60.3% due to:
    - $613.8 million unfavorable variance in Other Medical Expenses due primarily to CY 2024 and 2025 Medi-Cal Hospital DP
    - $44.0 million unfavorable variance to budget in Professional Claims due to higher utilization and adjustments relating to prior period Medi-Cal claims
    - Offset by $8.5 million favorable variance to budget in all other expense categories (net)

CalOptima Health

FY 2026-27: Management Summary (cont.)

- Administrative Expenses
  - MTD: $22.1 million, favorable to budget $3.2 million or 12.6% due to the timing of administrative expense activities
  - YTD: $65.8 million, favorable to budget $10.2 million or 13.4% due to the timing of administrative expense activities

FY 2026-27: Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: ($8.4) million, unfavorable to budget $16.6 million or 203.0% due to:
    - $17.4 million unfavorable variance to budget in Net Investment Income/Expense primarily due to unrealized loss on investments resulting from rising interest rates
    - Offset by net $0.7 million favorable variance from other non-operating activities
  - YTD: $10.7 million, unfavorable to budget $13.8 million or 56.2% due primarily to $14.1 million unfavorable variance to budget in Net Investment Income/Expense

CalOptima Health

FY 2026-27: Key Financial Ratios

- Medical Loss Ratio (MLR)

	Actual	Budget	Variance (%)
MTD	96.8%	95.6%	1.2%
YTD	96.2%	96.5%	(0.3%)

- Administrative Loss Ratio (ALR)

	Actual	Budget	Variance (%)
MTD	2.1%	6.9%	4.7%
YTD	3.7%	6.8%	3.1%

CalOptima Health

FY 2026-27: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.9
  - Board Designated Reserve level: 3.54
  - Statutory Designated Reserve level: 1.02
  - Net-position: $3.1 billion, including required TNE of $151.8 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

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Enrollment Summary: September 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
103,063	100,607	2,456	2.4%	FAM	313,604	305,428	8,176	2.7%
229,203	225,850	3,353	1.5%	CHD	692,979	683,254	9,725	1.4%
277,972	265,860	12,112	4.6%	MCE	841,750	809,186	32,564	4.0%
3,007	3,177	(170)	(5.4%)	LTC	9,029	9,529	(500)	(5.2%)
147,038	142,305	4,733	3.3%	SPD	442,909	429,231	13,678	3.2%
8,665	8,516	149	1.7%	WCM	25,585	25,645	(60)	(0.2%)
768,948	**746,315**	**22,633**	**3.0%**	**Medi-Cal Total**	**2,325,856**	**2,262,274**	**63,582**	**2.8%**
19,126	**19,604**	(478)	(2.4%)	**OneCare**	**57,235**	**58,474**	(1,239)	(2.1%)
593	**580**	**13**	**2.2%**	**PACE**	**1,747**	**1,728**	**19**	**1.1%**
546	**581**	(35)	(6.0%)	**MSSP***	**1,671**	**1,737**	(66)	(3.8%)
788,667	**766,499**	**22,168**	**2.9%**	**CalOptima Health Total**	**2,384,838**	**2,322,475**	**62,363**	**2.7%**

*MSSP enrollment is included in Medi-Cal total

Consolidated Revenue & Expenses: September 2026 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	768,948	19,126	593	546		788,667
REVENUES						
Capitation Revenue	$ 983,127,688	$ 40,538,408	$ 5,540,971	$ 224,537	$ -	$ 1,029,431,604
Total Operating Revenue	**983,127,688**	**40,538,408**	**5,540,971**	**224,537**	**-**	**1,029,431,604**
MEDICAL EXPENSES						
Provider Capitation	109,349,264	14,144,840				123,494,104
Facility and Professional Claims	163,794,059	7,876,644	2,632,988			174,303,691
MLTSS	49,130,941		71,182	17,944		49,220,067
Prescription Drugs		14,552,855	616,768			15,169,623
Case Mgmt & Other Medical	630,593,013	2,041,532	1,444,787	148,052		634,227,385
Total Medical Expenses	**952,867,277**	**38,615,870**	**4,765,725**	**165,997**	**-**	**996,414,869**
Medical Loss Ratio	*96.9%*	*95.3%*	*86.0%*	*73.9%*	*0.0%*	*96.8%*
GROSS MARGIN	**30,260,411**	**1,922,537**	**775,247**	**58,540**	**-**	**33,016,735**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	10,865,673	1,145,432	194,080	116,958	435,636	12,757,778
Non-Salary Operating Expenses	2,809,330	593,826	90,757	1,532	334,093	3,829,537
Depreciation & Amortization	1,256,301		1,180			1,257,481
Other Operating Expenses	3,624,715	21,631	6,753	8,661	11,116	3,672,875
Indirect Cost Allocation, Occupancy	151,619	443,924	13,434	1,125		610,102
Total Administrative Expenses	**18,707,637**	**2,204,812**	**306,203**	**128,276**	**780,844**	**22,127,773**
Administrative Loss Ratio	*1.9%*	*5.4%*	*5.5%*	*57.1%*	*0.0%*	*2.1%*
Operating Income/(Loss)	**11,552,773**	(282,275)	**469,043**	(69,736)	(780,844)	**10,888,962**
Investments and Other Non-Operating	2,282,232					(8,407,258)
CHANGE IN NET ASSETS	**$ 13,835,005**	$ (282,275)	**$ 469,043**	$ (69,736)	$ (780,844)	**$ 2,481,704**
BUDGETED CHANGE IN NET ASSETS	(7,127,353)	(810,643)	164,902	(121,648)	(1,315,546)	(1,048,966)
Variance to Budget - Fav/(Unfav)	$ 20,962,359	$ 528,368	$ 304,142	$ 51,912	$ 534,702	$ 3,530,670

CalOptima Health

Consolidated Revenue & Expenses: September 2026 YTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	2,325,856	57,235	1,747	1,671		2,384,838
REVENUES						
Capitation Revenue	$ 1,660,634,373	$ 115,509,765	$ 16,319,270	$ 692,929	$ -	$ 1,793,156,336
Total Operating Revenue	**1,660,634,373**	**115,509,765**	**16,319,270**	**692,929**	**-**	**1,793,156,336**
MEDICAL EXPENSES						
Provider Capitation	329,880,517	42,006,444				371,886,961
Facility and Professional Claims	455,504,930	27,029,818	7,117,200			489,651,949
MLTSS	150,449,413		234,537	57,810		150,741,760
Prescription Drugs		35,419,574	1,721,982			37,141,555
Case Mgmt & Other Medical	664,933,503	6,635,645	4,373,060	497,705		676,439,913
Total Medical Expenses	**1,600,768,364**	**111,091,480**	**13,446,779**	**555,516**	**-**	**1,725,862,138**
Medical Loss Ratio	*96.4%*	*96.2%*	*82.4%*	*80.2%*	*0.0%*	*96.2%*
GROSS MARGIN	**59,866,009**	**4,418,285**	**2,872,490**	**137,413**	**-**	**67,294,198**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	33,602,166	3,343,545	614,216	342,584	1,048,388	38,950,899
Non-Salary Operating Expenses	9,096,768	1,589,836	192,680	4,594	790,363	11,674,242
Depreciation & Amortization	3,826,012		3,435			3,829,447
Other Operating Expenses	9,544,102	66,901	37,429	24,153	11,158	9,683,743
Indirect Cost Allocation, Occupancy	(1,174,513)	2,798,064	48,114	16,785		1,688,450
Total Administrative Expenses	**54,894,535**	**7,798,346**	**895,874**	**388,116**	**1,849,909**	**65,826,781**
Administrative Loss Ratio	*3.3%*	*6.8%*	*5.5%*	*56.0%*	*0.0%*	*3.7%*
Operating Income/(Loss)	**4,971,474**	(3,380,061)	**1,976,616**	(250,703)	(1,849,909)	**1,467,417**
Investments and Other Non-Operating	3,080,019					10,732,522
CHANGE IN NET ASSETS	**$ 8,051,493**	$ (3,380,061)	**$ 1,976,616**	$ (250,703)	$ (1,849,909)	**$ 12,199,939**
BUDGETED CHANGE IN NET ASSETS	(29,596,306)	(3,558,096)	349,422	(371,296)	(3,899,882)	(12,592,189)
Variance to Budget - Fav/(Unfav)	$ 37,647,799	$ 178,035	$ 1,627,194	$ 120,593	$ 2,049,973	$ 24,792,128

CalOptima Health

Balance Sheet: As of September 2026

ASSETS	
Current Assets	
Operating Cash	$261,510,007
Short-term Investments	1,858,175,339
Capitation Receivable	583,450,343
Receivables - Other	15,593,544
Prepaid Expenses	43,845,945
Total Current Assets	**2,762,575,178**
Capital Assets	
Capital Assets	227,338,470
Less: Accumulated Depreciation	(99,949,741)
Capital Assets, Net of Depreciation	**127,388,730**
Other Assets	
Net Pension Assets	4,069,081
Restricted Deposit	300,000
Board Designated Reserves	1,632,666,074
Statutory Designated Reserves	155,188,633
Total Other Assets	**1,792,223,788**
TOTAL ASSETS	**4,682,187,696**
Deferred Outflows	**30,923,013**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$4,713,110,709**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$221,073,714
Medical Claims Liability	357,833,429
Accrued Payroll Liabilities	30,015,794
Deferred Revenue	5,851,767
Due to State of California and CMS	703,762,892
Capitation and Withholds	137,476,993
Total Current Liabilities	**1,456,014,589**
Other Liabilities	
GASB 96 Subscription Liabilities	32,023,336
Community Reinvestment	64,997,176
Capital Lease Payable	183,953
Post Employment Health Benefits Liability	15,837,052
Net Pension Liabilities	0
Total Other Liabilities	**113,041,516**
TOTAL LIABILITIES	**1,569,056,106**
Deferred Inflows	**16,723,193**
Net Position	
Required TNE	151,766,779
Funds in Excess of TNE	2,975,564,631
TOTAL NET POSITION	**3,127,331,410**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**$4,713,110,709**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of September 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	815,335,413				
MetLife Tier One	817,330,660				
Board Designated Reserves	1,632,666,074	1,154,279,662	1,846,847,459	478,386,411	(214,181,386)
revenue) [1]	*3.54*	*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	77,666,204				
MetLife Tier Two	77,522,429				
Statutory Designated Reserves	155,188,633	151,766,779	166,943,457	3,421,854	(11,754,823)
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 September 2026

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @9/30/2026	**$3,127.3**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,632.7**			**52.2%**
Statutory Designated Reserve[1]	**$155.2**			**5.0%**
Capital Assets, net of Depreciation	**$127.4**			**4.1%**
Resources Allocated				
Homeless Health Initiative (HHI)[2]	13.9	63.3	49.4	0.4%
Housing and Homelessness Incentive Program (HHIP)[2]	26.6	87.4	60.8	0.8%
Intergovernmental Transfers (IGT)	34.2	52.1	17.9	1.1%
Digital Transformation and Workplace Modernization[3]	18.9	100.0	81.1	0.6%
CalFresh and Redetermination Outreach Strategy	1.5	6.0	4.5	0.0%
Coalition of Orange County Community Health Centers Grant	10.7	50.0	39.3	0.3%
General Awareness Campaign	0.0	4.7	4.7	0.0%
Member Health Needs Assessment	0.3	1.3	1.1	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	100.3	153.5	53.2	3.2%
Skilled Nursing Facility Access Program	10.0	10.0	-	0.3%
National Alliance for Mental Illness Orange County Peer Support Program Grant	1.5	5.0	3.5	0.0%
Stipend Program for Master of Social Work Students Grant	-	5.0	5.0	0.0%
Wellness & Prevention Program Grant	0.7	2.7	2.0	0.0%
CalOptima Health Provider Workforce Development Fund Grant	17.5	30.1	12.6	0.6%
Garden Grove Bldg. Improvement	16.0	17.5	1.6	0.5%

Spending Plan: As of September 2026 (cont.)

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Dyadic Services Program Academy	0.2	1.9	1.7	0.0%
Medi-Cal Provider Rate Increases (07/2024 - 12/2026)	52.6	526.2	473.6	1.7%
Medi-Cal Provider Rate Increases (07/2026 - 12/2028)	386.6	429.6	43.0	12.4%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.0	0.3	0.2	0.0%
Medi-Cal Eligibility Outreach Strategy	19.8	21.8	2.0	0.6%
Supplemental Food Support for Medi-Cal Members	3.8	8.0	4.2	0.1%
Orange County Community Health Assessment and Improvement Plan	0.5	1.0	0.5	0.0%
PACE Facility - Irvine	28.7	29.5	0.9	0.9%
Subtotal	**744.2**	**1,607.1**	**862.9**	**23.8%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$467.9**			**15.0%**

[1]Total Designated Reserves and unallocated reserve amount can support approximately 176 days of CalOptima Health's current operations.
[2]See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[3]On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of September 2026

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	61,496,005	61,496,005	49,417,870	12,078,135	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**103,396,005**	**103,396,005**	**49,417,870**	**53,978,135**	**-**

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[6]	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)[4]	-	-	-	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	10,000,000	-	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support[5]	925,540	925,540	-	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	5,104,626	4,784,287	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[3]	14,279,077	9,909,215	4,369,862	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**103,396,005**	**49,417,870**	**53,978,135**	
Transfer of funds to HHIP[4]	(40,100,000)	-	(40,100,000)	
Program Total	**63,296,005**	**49,417,870**	**13,878,135**	

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

[2]On June 5, 2025, CalOptima Health's Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program ($3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board action), to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[4]On February 5, 2026, CalOptima Health's Board of Directors approved the closeout of the Day Habilitation (County for HomeKey) and designated the remaining balance of $2.5 million as available for allocation to deliver enhanced services for Medi-Cal members.

[5]On April 2, 2026, CalOptima Health's Board of Directors approved the closeout of the CalOptima Days, HCAP and FQHC Administrative Support and make $37,721 in IGT 8 funds available toward future IGT initiatives to deliver covered services for Medi-Cal members.

[6]Following the early termination agreement with the Orange County Health Authority, effective September 4, 2026, CalOptima Health received a refund of advance funding totaling $10,965,968 on October 2, 2026.

CalOptima Health

Housing and Homelessness Incentive Program: As of September 2026

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	65,931,189	65,931,189	35,095,097	30,836,093	-
Existing Reserves & HHI Transfer	87,384,530	87,384,530	60,820,559	26,563,971	-
Street Medicine Support Center - GG Building[2]	7,000,000	7,000,000	-	7,000,000	-
Total	**160,315,719**	**160,315,719**	**95,915,656**	**64,400,064**	-

Funds Allocation, Approved Initiatives:	Allocated Amount	Utilized Amount	Remaining	Funding Source(s)
Office of Care Coordination	2,056,488	2,056,488	-	HHI
Pulse For Good	1,400,000	917,350	482,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,821,311	800,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,832,310	4	HHI
Capital Projects	135,997,542	72,303,100	63,694,442	HHI & Existing Reserves
System Change Projects	16,214,530	10,329,707	5,884,823	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**166,822,185**	**95,915,656**	**70,906,529**	
Transfer of funds to Street Medicine Support Center-GG Building	**(7,000,000)**	**-**	**(7,000,000)**	Existing Reserves
Program Total	**159,822,185**	**95,915,656**	**63,906,529**	

[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.

[2]On October 7, 2025, CalOptima Health's Board of Directors approved up to $7.0 million for general contractor services & furniture, fixtures & equipment for the Street Medicine Support Center.

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UNAUDITED FINANCIAL STATEMENTS

September 30, 2026

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CalOptima Health - Consolidated
Financial Highlights
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
788,667	766,499	22,168	2.9%	Member Months	2,384,838	2,322,475	62,363	2.7%
1,029,431,604	368,664,341	660,767,263	179.2%	Revenues	1,793,156,336	1,115,592,105	677,564,231	60.7%
996,414,869	352,570,986	(643,843,883)	(182.6%)	Medical Expenses[1]	1,725,862,138	1,076,620,460	(649,241,678)	(60.3%)
22,127,773	25,303,644	3,175,871	12.6%	Administrative Expenses	65,826,781	76,047,803	10,221,022	13.4%
10,888,962	(9,210,289)	**20,099,251**	**218.2%**	**Operating Margin**	**1,467,417**	(37,076,158)	**38,543,575**	**104.0%**
				Non-Operating Income (Loss)				
(9,073,869)	8,333,330	(17,407,199)	(208.9%)	Net Investment Income/Expense	10,873,745	24,999,990	(14,126,245)	(56.5%)
(1,669,584)	-	(1,669,584)	(100.0%)	Grant Expense	(2,964,491)	-	(2,964,491)	(100.0%)
1,150,050	-	1,150,050	100.0%	Community Reinvestment	1,944,162	-	1,944,162	100.0%
1,186,145	(172,007)	1,358,152	789.6%	Other Income/Expense	879,106	(516,021)	1,395,127	270.4%
(8,407,258)	**8,161,323**	(16,568,581)	(203.0%)	**Total Non-Operating Income (Loss)**	**10,732,522**	**24,483,969**	(13,751,447)	(56.2%)
2,481,704	(1,048,966)	**3,530,670**	**336.6%**	**Change in Net Assets**	**12,199,939**	(12,592,189)	**24,792,128**	**196.9%**
96.8%	*95.6%*	*1.2%*		*Medical Loss Ratio*	*96.2%*	*96.5%*	(0.3%)	
2.1%	*6.9%*	*4.7%*		*Administrative Loss Ratio*	*3.7%*	*6.8%*	*3.1%*	
1.1%	(2.5%)	*3.6%*		*Operating Margin Ratio*	*0.1%*	(3.3%)	*3.4%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		

[1]Actual Medical Expenses include the Board-approved Provider Rate Increases

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CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Three Months Ending September 30, 2026

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,319	1,411	92
OneCare	171	183	12
PACE	110	121	11
CCA	33	25	(8)
MSSP	20	24	4
Total	1,652	1,764	112

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	3,951	4,234	283
OneCare	507	548	41
PACE	333	362	29
CCA	72	74	2
MSSP	62	71	9
Total	4,925	5,289	364

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	583	529	(54)
OneCare	112	107	(5)
PACE	5	5	0
CCA	0	0	0
MSSP	28	24	(4)
Consolidated	477	435	(42)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	589	534	(55)
OneCare	113	107	(6)
PACE	5	5	0
CCA	0	0	0
MSSP	27	24	(3)
Consolidated	484	439	(45)

Open FTE			
	Total	Medical	Admin
Medi-Cal	74	32	42
OneCare	8	5	3
PACE	11	11	0
CCA	17	1	16
MSSP	1	1	0
Total	111	50	61

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending September 30, 2026

MEMBER MONTHS		788,667		766,499		22,168
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$983,127,688	$1,278.54	$324,307,382	$434.54	$658,820,306	$844.00
OneCare	40,538,408	2,119.54	38,789,251	1,978.69	1,749,156	140.85
PACE	5,540,971	9,343.97	5,308,387	9,152.39	232,584	191.58
MSSP	224,537	411.24	259,320	446.33	(34,783)	(35.09)
Total Operating Revenue	1,029,431,604	1,305.28	368,664,341	480.97	660,767,263	824.31
MEDICAL EXPENSES						
Medi-Cal	952,867,277	1,239.18	311,018,281	416.74	(641,848,996)	(822.44)
OneCare	38,615,870	2,019.02	36,342,055	1,853.85	(2,273,815)	(165.17)
PACE	4,765,725	8,036.64	4,794,366	8,266.15	28,641	229.51
MSSP	165,997	304.02	247,918	426.71	81,921	122.69
Covered CA			168,365		168,365	
Total Medical Expenses	996,414,869	1,263.42	352,570,986	459.98	(643,843,883)	(803.44)
GROSS MARGIN	33,016,735	41.86	16,093,355	20.99	16,923,379	20.87
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,757,778	16.64	13,973,116	18.23	1,215,338	1.59
Professional Fees	1,354,291	1.77	2,014,125	2.63	659,834	0.86
Purchased Services	2,054,116	2.68	2,477,366	3.23	423,250	0.55
Printing & Postage	421,130	0.55	513,323	0.67	92,193	0.12
Depreciation & Amortization	1,257,481	1.64	1,117,682	1.46	(139,799)	(0.18)
Other Expenses	3,672,875	4.79	4,635,192	6.05	962,316	1.26
Indirect Cost Allocation, Occupancy	610,102	0.80	572,841	0.75	(37,261)	(0.05)
Total Administrative Expenses	22,127,773	28.06	25,303,644	33.01	3,175,871	4.95
NET INCOME (LOSS) FROM OPERATIONS	10,888,962	13.81	(9,210,289)	(12.02)	20,099,251	25.83
INVESTMENT INCOME						
Interest Income	15,127,767	19.18	8,582,330	11.20	6,545,437	7.98
Realized Gain/(Loss) on Investments	(1,334,880)	(1.69)	-	-	(1,334,880)	(1.69)
Unrealized Gain/(Loss) on Investments	(22,667,710)	(28.74)	-	-	(22,667,710)	(28.74)
Investment Fees	(199,046)	(0.25)	(249,000)	(0.32)	49,954	0.07
Total Investment Income	(9,073,869)	(11.51)	8,333,330	10.87	(17,407,199)	(22.38)
NET BUILDING INCOME/EXPENSE	53,965	0.07	(172,007)	(0.22)	225,972	0.29
NET MCO TAX	1,130,230	1.43	-	-	1,130,230	1.43
GRANT EXPENSE	(1,669,584)	(2.12)	-	-	(1,669,584)	(2.12)
COMMUNITY REINVESTMENT	1,150,050	1.46	-	-	1,150,050	1.46
OTHER INCOME/EXPENSE	1,950	-	-	-	1,950	-
CHANGE IN NET ASSETS	**2,481,704**	**3.15**	(1,048,966)	(1.37)	**3,530,670**	**4.52**
MEDICAL LOSS RATIO	**96.8%**		**95.6%**		**1.2%**	
ADMINISTRATIVE LOSS RATIO	**2.1%**		**6.9%**		**4.7%**	

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

MEMBER MONTHS		2,384,838		2,322,475		62,363
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$1,660,634,373	$713.99	$982,705,964	$434.39	$677,928,409	$279.60
OneCare	115,509,765	2,018.17	116,259,898	1,988.25	(750,134)	29.92
PACE	16,319,270	9,341.31	15,850,961	9,173.01	468,308	168.30
MSSP	692,929	414.68	775,281	446.33	(82,352)	(31.65)
Total Operating Revenue	1,793,156,336	751.90	1,115,592,105	480.35	677,564,231	271.55
MEDICAL EXPENSES						
Medi-Cal	1,600,768,364	688.25	950,889,231	420.32	(649,879,133)	(267.93)
OneCare	111,091,480	1,940.97	110,028,316	1,881.68	(1,063,164)	(59.29)
PACE	13,446,779	7,697.07	14,451,811	8,363.32	1,005,032	666.25
MSSP	555,516	332.44	746,006	429.48	190,490	97.04
Covered CA			505,096		505,096	
Total Medical Expenses	1,725,862,138	723.68	1,076,620,460	463.57	(649,241,678)	(260.11)
GROSS MARGIN	67,294,198	28.22	38,971,645	16.78	28,322,553	11.44
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	38,950,899	16.77	42,077,657	18.12	3,126,758	1.35
Professional Fees	4,426,296	1.91	6,047,055	2.60	1,620,759	0.69
Purchased Services	6,411,165	2.76	7,410,746	3.19	999,581	0.43
Printing & Postage	836,781	0.36	1,539,969	0.66	703,188	0.30
Depreciation & Amortization	3,829,447	1.65	3,353,046	1.44	(476,401)	(0.21)
Other Expenses	9,683,743	4.17	13,900,808	5.99	4,217,064	1.82
Indirect Cost Allocation, Occupancy	1,688,450	0.73	1,718,523	0.74	30,073	0.01
Total Administrative Expenses	65,826,781	27.60	76,047,803	32.74	10,221,022	5.14
NET INCOME (LOSS) FROM OPERATIONS	1,467,417	0.62	(37,076,158)	(15.96)	38,543,575	16.58
INVESTMENT INCOME						
Interest Income	42,637,005	17.88	25,746,990	11.09	16,890,015	6.79
Realized Gain/(Loss) on Investments	(2,961,103)	(1.24)	-	-	(2,961,103)	(1.24)
Unrealized Gain/(Loss) on Investments	(28,197,398)	(11.82)	-	-	(28,197,398)	(11.82)
Investment Fees	(604,759)	(0.25)	(747,000)	(0.32)	142,241	0.07
Total Investment Income	10,873,745	4.56	24,999,990	10.76	(14,126,245)	(6.20)
NET BUILDING INCOME/EXPENSE	(256,749)	(0.11)	(516,021)	(0.22)	(196,722)	0.11
NET MCO TAX	1,130,230	0.47	-	-	1,130,230	0.47
GRANT EXPENSE	(2,964,491)	(1.24)	-	-	(2,964,491)	(1.24)
COMMUNITY REINVESTMENT	1,944,162	0.82	-	-	1,944,162	0.82
OTHER INCOME/EXPENSE	5,625	-	-	-	5,625	-
CHANGE IN NET ASSETS	**12,199,939**	**5.12**	(12,592,189)	(5.42)	**24,792,128**	**10.54**
MEDICAL LOSS RATIO	**96.2%**		**96.5%**		(0.3%)	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**6.8%**		**3.1%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending September 30, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	768,948	19,126	593	546		788,667
REVENUES						
Capitation Revenue	$ 983,127,688	$ 40,538,408	$ 5,540,971	$ 224,537	$ -	$ 1,029,431,604
Total Operating Revenue	**983,127,688**	**40,538,408**	**5,540,971**	**224,537**	**-**	**1,029,431,604**
MEDICAL EXPENSES						
Provider Capitation	109,349,264	14,144,840				123,494,104
Facility and Professional Claims	163,794,059	7,876,644	2,632,988			174,303,691
MLTSS	49,130,941		71,182	17,944		49,220,067
Prescription Drugs		14,552,855	616,768			15,169,623
Case Mgmt & Other Medical	630,593,013	2,041,532	1,444,787	148,052		634,227,385
Total Medical Expenses	**952,867,277**	**38,615,870**	**4,765,725**	**165,997**	**-**	**996,414,869**
Medical Loss Ratio	*96.9%*	*95.3%*	*86.0%*	*73.9%*	*0.0%*	*96.8%*
GROSS MARGIN	**30,260,411**	**1,922,537**	**775,247**	**58,540**	**-**	**33,016,735**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	10,865,673	1,145,432	194,080	116,958	435,636	12,757,778
Non-Salary Operating Expenses	2,809,330	593,826	90,757	1,532	334,093	3,829,537
Depreciation & Amortization	1,256,301		1,180			1,257,481
Other Operating Expenses	3,624,715	21,631	6,753	8,661	11,116	3,672,875
Indirect Cost Allocation, Occupancy	151,619	443,924	13,434	1,125		610,102
Total Administrative Expenses	**18,707,637**	**2,204,812**	**306,203**	**128,276**	**780,844**	**22,127,773**
Administrative Loss Ratio	*1.9%*	*5.4%*	*5.5%*	*57.1%*	*0.0%*	*2.1%*
Operating Income/(Loss)	**11,552,773**	(282,275)	**469,043**	(69,736)	(780,844)	**10,888,962**
Investments and Other Non-Operating	2,282,232					(8,407,258)
CHANGE IN NET ASSETS	**$ 13,835,005**	$ (282,275)	**$ 469,043**	$ (69,736)	$ (780,844)	**$ 2,481,704**
BUDGETED CHANGE IN NET ASSETS	(7,127,353)	(810,643)	164,902	(121,648)	(1,315,546)	(1,048,966)
Variance to Budget - Fav/(Unfav)	$ 20,962,359	$ 528,368	$ 304,142	$ 51,912	$ 534,702	$ 3,530,670

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ending September 30, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	2,325,856	57,235	1,747	1,671		2,384,838
REVENUES						
Capitation Revenue	$ 1,660,634,373	$ 115,509,765	$ 16,319,270	$ 692,929	$ -	$ 1,793,156,336
Total Operating Revenue	**1,660,634,373**	**115,509,765**	**16,319,270**	**692,929**	**-**	**1,793,156,336**
MEDICAL EXPENSES						
Provider Capitation	329,880,517	42,006,444				371,886,961
Facility and Professional Claims	455,504,930	27,029,818	7,117,200			489,651,949
MLTSS	150,449,413		234,537	57,810		150,741,760
Prescription Drugs		35,419,574	1,721,982			37,141,555
Case Mgmt & Other Medical	664,933,503	6,635,645	4,373,060	497,705		676,439,913
Total Medical Expenses	**1,600,768,364**	**111,091,480**	**13,446,779**	**555,516**	**-**	**1,725,862,138**
Medical Loss Ratio	*96.4%*	*96.2%*	*82.4%*	*80.2%*	*0.0%*	*96.2%*
GROSS MARGIN	**59,866,009**	**4,418,285**	**2,872,490**	**137,413**	**-**	**67,294,198**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	33,602,166	3,343,545	614,216	342,584	1,048,388	38,950,899
Non-Salary Operating Expenses	9,096,768	1,589,836	192,680	4,594	790,363	11,674,242
Depreciation & Amortization	3,826,012		3,435			3,829,447
Other Operating Expenses	9,544,102	66,901	37,429	24,153	11,158	9,683,743
Indirect Cost Allocation, Occupancy	(1,174,513)	2,798,064	48,114	16,785		1,688,450
Total Administrative Expenses	**54,894,535**	**7,798,346**	**895,874**	**388,116**	**1,849,909**	**65,826,781**
Administrative Loss Ratio	*3.3%*	*6.8%*	*5.5%*	*56.0%*	*0.0%*	*3.7%*
Operating Income/(Loss)	**4,971,474**	(3,380,061)	**1,976,616**	(250,703)	(1,849,909)	**1,467,417**
Investments and Other Non-Operating	3,080,019					10,732,522
CHANGE IN NET ASSETS	**$ 8,051,493**	$ (3,380,061)	**$ 1,976,616**	$ (250,703)	$ (1,849,909)	**$ 12,199,939**
BUDGETED CHANGE IN NET ASSETS	(29,596,306)	(3,558,096)	349,422	(371,296)	(3,899,882)	(12,592,189)
Variance to Budget - Fav/(Unfav)	$ 37,647,799	$ 178,035	$ 1,627,194	$ 120,593	$ 2,049,973	$ 24,792,128

CalOptima Health

Highlights – Consolidated, for the Three Months Ending September 30, 2026

MONTH TO DATE RESULTS:

- Change in Net Assets is $2.5 million, favorable to budget $3.5 million
- Operating surplus is $10.9 million, with a deficit in non-operating income of $8.4 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $12.2 million, favorable to budget $24.8 million
- Operating surplus is $1.5 million, with a surplus in non-operating income of $10.7 million

Change in Net Assets by Line of Business (LOB) ($ millions):

September 2026				July 2026 -September 2026		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
11.6	(7.1)	18.7	Medi-Cal	5.0	(29.6)	34.6
(0.3)	(0.8)	0.5	OneCare	(3.4)	(3.6)	0.2
0.5	0.2	0.3	PACE	2.0	0.3	1.6
(0.1)	(0.1)	0.1	MSSP	(0.3)	(0.4)	0.1
(0.8)	(1.3)	0.5	Covered CA	(1.8)	(3.9)	2.0
10.9	**(9.2)**	**20.1**	**Total Operating Income (Loss)**	**1.5**	**(37.1)**	**38.5**
			Non-Operating Income (Loss)			
(9.1)	8.3	(17.4)	Net Investment Income/Expense	10.9	25.0	(14.1)
0.7	(0.2)	0.8	Other Income/Expense	0.0	(0.1)	(0.5)
(8.4)	**8.2**	**(16.6)**	**Total Non-Operating Income/(Loss)**	**10.7**	**24.5**	**(13.8)**
2.5	**(1.0)**	**3.5**	**TOTAL**	**12.2**	**(12.6)**	**24.8**

CalOptima Health - Consolidated
Enrollment Summary
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
103,063	100,607	2,456	2.4%	Adult	313,604	305,428	8,176	2.7%
229,203	225,850	3,353	1.5%	Child	692,979	683,254	9,725	1.4%
277,972	265,860	12,112	4.6%	Expansion	841,750	809,186	32,564	4.0%
3,007	3,177	(170)	(5.4%)	LTC	9,029	9,529	(500)	(5.2%)
147,038	142,305	4,733	3.3%	SPD	442,909	429,231	13,678	3.2%
8,665	8,516	149	1.7%	Whole Child Model	25,585	25,645	(60)	(0.2%)
768,948	**746,315**	**22,633**	**3.0%**	**Medi-Cal Total**	**2,325,856**	**2,262,274**	**63,582**	**2.8%**
19,126	**19,604**	(478)	(2.4%)	**OneCare**	**57,235**	**58,474**	(1,239)	(2.1%)
593	**580**	**13**	**2.2%**	**PACE**	**1,747**	**1,728**	**19**	**1.1%**
546	**581**	(35)	(6.0%)	**MSSP**	**1,671**	**1,737**	(66)	(3.8%)
788,667	**766,499**	**22,168**	**2.9%**	**CalOptima Health Total**	**2,384,838**	**2,322,475**	**62,363**	**2.7%**
				Enrollment (by Network)				
292,162	281,041	11,121	4.0%	HMO	887,531	855,493	32,038	3.7%
149,009	142,188	6,821	4.8%	PHC	448,605	431,374	17,231	4.0%
72,021	64,116	7,905	12.3%	Shared Risk Group	216,957	193,904	23,053	11.9%
255,756	258,969	(3,213)	(1.2%)	Fee for Service	772,763	781,502	(8,739)	(1.1%)
768,948	**746,315**	**22,633**	**3.0%**	**Medi-Cal Total**	**2,325,856**	**2,262,274**	**63,582**	**2.8%**
19,126	**19,604**	(478)	(2.4%)	**OneCare**	**57,235**	**58,474**	(1,239)	(2.1%)
593	**580**	**13**	**2.2%**	**PACE**	**1,747**	**1,728**	**19**	**1.1%**
546	**581**	(35)	(6.0%)	**MSSP**	**1,671**	**1,737**	(66)	(3.8%)
788,667	**766,499**	**22,168**	**2.9%**	**CalOptima Health Total**	**2,384,838**	**2,322,475**	**62,363**	**2.7%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2027

	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27	YTD Actual	YTD Budget	Variance
HMOs															
Adult	56,598	55,758	54,840										167,196	162,928	4,268
Child	66,323	65,482	64,642										196,447	195,564	883
Expansion	156,202	154,485	152,672										463,359	436,796	26,563
LTC		1	2										3		3
SPD	19,058	18,886	18,730										56,674	56,206	468
Whole Child Model	1,336	1,240	1,276										3,852	3,999	(147)
Total	299,517	295,852	292,162										887,531	855,493	**32,038**
PHCs															
Adult	2,971	2,916	2,807										8,694	8,229	465
Child	118,528	117,898	117,580										354,006	344,801	9,205
Default Code		0											0		0
Expansion	18,332	18,184	18,064										54,580	47,932	6,648
LTC	1	0											1		1
SPD	4,462	4,547	4,542										13,551	12,645	906
Whole Child Model	5,938	5,819	6,016										17,773	17,767	6
Total	150,232	149,364	149,009										448,605	431,374	**17,231**
Shared Risk Groups															
Adult	12,566	12,566	12,462										37,594	36,973	621
Child	20,692	20,574	20,324										61,590	60,025	1,565
Expansion	35,090	34,844	34,966										104,900	83,928	20,972
LTC	4	0	2										6		6
SPD	3,955	4,037	3,913										11,905	11,808	97
Whole Child Model	316	292	354										962	1,171	(209)
Total	72,623	72,313	72,021										216,957	193,904	23,053
Fee for Service (Dual)															
Adult	737	748	723										2,208	1,516	692
Expansion	2,524	2,565	2,625										7,714	9,203	(1,489)
LTC	2,679	2,679	2,681										8,039	8,404	(365)
SPD	107,375	107,026	106,782										321,183	308,509	12,674
Whole Child Model	10	10	11										31	32	(1)
Total	113,325	113,028	112,822										339,175	327,665	11,510
Fee for Service (Non-Dual - Total)															
Adult	33,148	32,533	32,231										97,912	95,782	2,130
Child	27,345	26,934	26,657										80,936	82,864	(1,928)
Expansion	71,105	70,447	69,645										211,197	231,327	(20,130)
LTC	320	338	322										980	1,125	(145)
SPD	13,319	13,206	13,071										39,596	40,063	(467)
Whole Child Model	1,013	946	1,008										2,967	2,676	291
Total	146,250	144,404	142,934										433,588	453,837	(20,249)
Grand Totals															
Total MediCal MM	**781,947**	**774,961**	**768,948**										**2,325,856**	**2,262,274**	**63,582**
OneCare	**18,963**	**19,146**	**19,126**										**57,235**	**58,474**	(1,239)
PACE	**573**	**581**	**593**										**1,747**	**1,728**	**19**
MSSP	**566**	**559**	**546**										**1,671**	**1,737**	(66)
Grand Total	**801,483**	**794,688**	**788,667**										**2,384,838**	**2,322,475**	**62,363**

Note:* Total membership does not include MSSP

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ENROLLMENT– SEPTEMBER MONTH:

Overall, September enrollment was 788,667

- Favorable to budget 22,168 or 2.9%
- Decreased 6,021 or 0.8% from Prior Month (PM) (August 2026)
- Decreased 96,647 or 10.9% from Prior Year (PY) (September 2025)

Medi-Cal enrollment was 768,948

- Favorable to budget 22,633 or 3.0% due to lower-than-expected disenrollment from federal and state policy changes and eligibility redetermination
- Medi-Cal Expansion (MCE) enrollment favorable to budget 12,112
- Seniors and Persons with Disabilities (SPD) enrollment favorable to budget 4,733
- Child (CHD) enrollment favorable to budget 3,353
- Adult (FAM) enrollment favorable to budget 2,456
- Whole Child Model (WCM) enrollment favorable to budget 149
- Long-Term Care (LTC) enrollment unfavorable to budget 170
- Decreased 6,013 or 0.8% from PM

OneCare enrollment was 19,126

- Unfavorable to budget 478 or 2.4%
- Decreased 20 or 0.1% from PM

PACE enrollment was 593

- Favorable to budget 13 or 2.2%
- Increased 12 or 2.1% from PM

MSSP enrollment was 546

- Unfavorable to budget 35 or 6.0%
- Decreased 13 or 2.3% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
768,948	**746,315**	**22,633**	**3.0%**	**Member Months**	**2,325,856**	**2,262,274**	**63,582**	**2.8%**
				Revenues				
983,127,688	324,307,382	658,820,306	203.1%	Capitation Revenue	1,660,634,373	982,705,964	677,928,409	69.0%
983,127,688	**324,307,382**	**658,820,306**	**203.1%**	**Total Operating Revenue**	**1,660,634,373**	**982,705,964**	**677,928,409**	**69.0%**
				Medical Expenses				
109,349,264	105,712,983	(3,636,282)	(3.4%)	Provider Capitation	329,880,517	321,319,667	(8,560,850)	(2.7%)
71,177,955	68,015,724	(3,162,230)	(4.6%)	Facilities Claims	201,559,788	208,978,993	7,419,205	3.6%
92,616,104	68,777,831	(23,838,274)	(34.7%)	Professional Claims	253,945,142	211,138,831	(42,806,311)	(20.3%)
49,130,941	46,775,454	(2,355,486)	(5.0%)	MLTSS	150,449,413	143,935,188	(6,514,225)	(4.5%)
5,980,554	7,942,068	1,961,514	24.7%	Incentive Payments	16,838,925	23,969,741	7,130,816	29.7%
8,995,949	10,754,701	1,758,752	16.4%	Medical Management	25,459,773	32,339,952	6,880,179	21.3%
615,616,510	3,039,520	(612,576,990)	(20153.7%)	Other Medical Expenses	622,634,805	9,206,859	(613,427,946)	(6662.7%)
952,867,277	**311,018,281**	(641,848,996)	(206.4%)	**Total Medical Expenses**	**1,600,768,364**	**950,889,231**	(649,879,133)	(68.3%)
30,260,411	**13,289,101**	**16,971,310**	**127.7%**	**Gross Margin**	**59,866,009**	**31,816,733**	**28,049,277**	**88.2%**
				Administrative Expenses				
10,865,673	11,775,140	909,467	7.7%	Salaries, Wages & Employee Benefits	33,602,166	35,460,555	1,858,389	5.2%
1,089,732	1,651,087	561,355	34.0%	Professional Fees	3,715,712	4,957,941	1,242,229	25.1%
1,458,890	1,661,717	202,827	12.2%	Purchased Services	4,893,099	5,013,779	120,681	2.4%
260,708	324,409	63,701	19.6%	Printing & Postage	487,958	973,227	485,269	49.9%
1,256,301	1,116,060	(140,241)	(12.6%)	Depreciation & Amortization	3,826,012	3,348,180	(477,832)	(14.3%)
3,624,715	4,545,709	920,994	20.3%	Other Operating Expenses	9,544,102	13,632,359	4,088,256	30.0%
151,619	(657,667)	(809,286)	(123.1%)	Indirect Cost Allocation, Occupancy	(1,174,513)	(1,973,001)	(798,488)	(40.5%)
18,707,637	**20,416,454**	**1,708,817**	**8.4%**	**Total Administrative Expenses**	**54,894,535**	**61,413,039**	**6,518,504**	**10.6%**
11,552,773	(7,127,353)	**18,680,127**	**262.1%**	**Income (Loss) From Operations**	**4,971,474**	(29,596,306)	**34,567,780**	**116.8%**
				Non-Operating Income (Loss)				
1,130,230	-	1,130,230	0.0%	Total Operating Tax	1,130,230	-	1,130,230	100.0%
1,150,050	-	1,150,050	100.0%	Community Reinvestment	1,944,162	-	1,944,162	100.0%
1,952	-	1,952	0.0%	Other Income/Expense	5,627	-	5,627	100.0%
2,282,232	**-**	**2,282,232**	**100.0%**	**Total Non-Operating Income/(Loss)**	**3,080,019**	**-**	**3,080,019**	**100.0%**
13,835,005	(7,127,353)	**20,962,359**	**294.1%**	**Change in Net Assets**	**8,051,493**	(29,596,306)	**37,647,799**	**127.2%**
96.9%	***95.9%***	***1.0%***		***Medical Loss Ratio***	***96.4%***	***96.8%***	(0.4%)	
1.9%	***6.3%***	***4.4%***		***Admin Loss Ratio***	***3.3%***	***6.2%***	***2.9%***	

MEDI-CAL INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES are $983.1 million, favorable to budget $658.8 million:

- Favorable volume-related variance of $9.8 million
- Favorable price-related variance of $649.0 million
  - $612.7 million of revenue received for Calendar Year (CY) 2024 Phase 2 and 2025 Phase 1 Hospital Directed Payments (DP)
  - $29.8 million due to updated CY 2025 premium capitation rates received from the Department of Health Care Services (DHCS) and the release of related accruals

MEDICAL EXPENSES are $952.9 million, unfavorable to budget $641.8 million:

- Unfavorable volume-related variance of $9.4 million
- Unfavorable price-related variance of $632.4 million
  - Other Medical Expenses unfavorable variance of $612.5 million due primarily to Hospital DP
  - Professional Claims expense unfavorable variance of $21.8 million due to increased utilization in mental health and Community Supports and adjustments relating to prior period claims
  - Facilities Claims expense unfavorable variance of $1.1 million
  - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $0.9 million
  - Provider Capitation expense unfavorable variance of $0.4 million
  - Offset by:
    - Incentive Payments expense favorable variance of $2.2 million
    - Medical Management expense favorable variance of $2.1 million

ADMINISTRATIVE EXPENSES are $18.7 million, favorable to budget $1.7 million:

- Non-Salary expense favorable to budget $0.8 million
- Salaries, Wages & Employee Benefits expense favorable variance of $0.9 million

NON-OPERATING INCOME/(LOSS) is $2.3 million, favorable to budget $2.3 million

CHANGE IN NET ASSETS is $13.8 million, favorable to budget $21.0 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
19,126	**19,604**	(478)	(2.4%)	**Member Months**	**57,235**	**58,474**	(1,239)	(2.1%)
				Revenues				
27,282,817	27,274,334	8,483	0.0%	Medicare Part C Revenue	80,897,472	81,889,876	(992,404)	(1.2%)
13,255,590	11,514,917	1,740,673	15.1%	Medicare Part D Revenue	34,612,293	34,370,023	242,270	0.7%
							-	
40,538,408	**38,789,251**	**1,749,156**	**4.5%**	**Total Operating Revenue**	**115,509,765**	**116,259,898**	(750,134)	(0.6%)
				Medical Expenses				
14,144,840	14,813,913	669,074	4.5%	Provider Capitation	42,006,444	44,599,419	2,592,976	5.8%
5,096,555	5,936,369	839,814	14.1%	Facilities Claims	18,496,364	17,999,384	(496,979)	(2.8%)
2,780,088	2,525,573	(254,515)	(10.1%)	Professional Claims	8,533,454	7,640,578	(892,877)	(11.7%)
14,552,855	10,717,812	(3,835,042)	(35.8%)	Prescription Drugs	35,419,574	32,794,735	(2,624,839)	(8.0%)
602,909	489,193	(113,716)	(23.2%)	Incentive Payments	1,650,813	1,413,742	(237,070)	(16.8%)
980,444	1,328,723	348,279	26.2%	Medical Management	3,056,208	3,998,163	941,955	23.6%
458,180	530,472	72,292	13.6%	Other Medical Expenses	1,928,624	1,582,294	(346,330)	(21.9%)
38,615,870	**36,342,055**	(2,273,815)	(6.3%)	**Total Medical Expenses**	**111,091,480**	**110,028,316**	(1,063,164)	(1.0%)
1,922,537	**2,447,196**	(524,659)	(21.4%)	**Gross Margin**	**4,418,285**	**6,231,583**	(1,813,297)	(29.1%)
				Administrative Expenses				
1,145,432	1,247,702	102,270	8.2%	Salaries, Wages & Employee Benefits	3,343,545	3,759,268	415,723	11.1%
134,161	128,800	(5,361)	(4.2%)	Professional Fees	261,434	386,400	124,966	32.3%
299,243	473,247	174,004	36.8%	Purchased Services	982,394	1,419,741	437,347	30.8%
160,422	137,106	(23,316)	(17.0%)	Printing & Postage	346,008	411,318	65,310	15.9%
21,631	66,401	44,770	67.4%	Other Operating Expenses	66,901	199,203	132,302	66.4%
443,924	1,204,583	760,659	63.1%	Indirect Cost Allocation, Occupancy	2,798,064	3,613,749	815,685	22.6%
2,204,812	**3,257,839**	**1,053,027**	**32.3%**	**Total Administrative Expenses**	**7,798,346**	**9,789,679**	**1,991,333**	**20.3%**
(282,275)	(810,643)	**528,368**	**65.2%**	**Change in Net Assets**	(3,380,061)	(3,558,096)	**178,035**	**5.0%**
95.3%	***93.7%***	***1.6%***		***Medical Loss Ratio***	***96.2%***	***94.6%***	***1.5%***	
5.4%	***8.4%***	***3.0%***		***Admin Loss Ratio***	***6.8%***	***8.4%***	***1.7%***	

ONECARE INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES are $40.5 million, favorable to budget $1.7 million:

- Unfavorable volume-related variance of $0.9 million
- Favorable price-related variance of $2.7 million due primarily to the impact of updated CY 2025 prescription drug rebates on the Part D payment reconciliation estimates

MEDICAL EXPENSES are $38.6 million, unfavorable to budget $2.3 million:

- Favorable volume-related variance of $0.9 million
- Unfavorable price-related variance of $3.2 million
  - Prescription Drugs expense unfavorable variance of $4.1 million due primarily to updated CY 2025 prescription drug rebates
  - Professional Claims expense unfavorable variance of $0.3 million
  - Incentive Payments expense unfavorable variance of $0.1 million
  - Offset by:
    - Facilities Claims expense favorable variance of $0.7 million
    - Medical Management expense favorable variance of $0.3 million
    - Provider Capitation expense favorable variance of $0.3 million
    - Other Medical Expenses favorable variance of $0.1 million

ADMINISTRATIVE EXPENSES are $2.2 million, favorable to budget $1.1 million

- Non-Salary expense favorable to budget $1.0 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($0.3) million, favorable to budget $0.5 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
593	**580**	13	2.2%	**Member Months**	**1,747**	**1,728**	**19**	**1.1%**
				Revenues				
4,111,446	3,991,865	119,581	3.0%	Medi-Cal Capitation Revenue	12,109,504	11,893,005	216,499	1.8%
1,054,736	922,191	132,545	14.4%	Medicare Part C Revenue	3,113,701	2,776,470	337,231	12.1%
374,790	394,332	(19,542)	(5.0%)	Medicare Part D Revenue	1,096,065	1,181,486	(85,421)	(7.2%)
5,540,971	**5,308,387**	**232,584**	**4.4%**	**Total Operating Revenue**	**16,319,270**	**15,850,961**	**468,308**	**3.0%**
				Medical Expenses				
1,444,787	1,756,903	312,116	17.8%	Medical Management	4,373,060	5,286,974	913,914	17.3%
1,141,105	1,082,906	(58,199)	(5.4%)	Facilities Claims	3,174,563	3,263,984	89,421	2.7%
1,147,739	899,008	(248,731)	(27.7%)	Professional Claims	2,910,655	2,715,095	(195,560)	(7.2%)
616,768	629,199	12,431	2.0%	Prescription Drugs	1,721,982	1,902,975	180,993	9.5%
71,182	109,075	37,893	34.7%	MLTSS	234,537	322,079	87,541	27.2%
344,144	313,898	(30,245)	(9.6%)	Patient Transportation	1,031,982	950,579	(81,403)	(8.6%)
-	3,375	3,375	100.0%	Other Medical Expenses	-	10,125	10,125	100.0%
4,765,725	**4,794,366**	**28,641**	**0.6%**	**Total Medical Expenses**	**13,446,779**	**14,451,811**	**1,005,032**	**7.0%**
775,247	**514,022**	**261,225**	**50.8%**	**Gross Margin**	**2,872,490**	**1,399,150**	**1,473,340**	**105.3%**
				Administrative Expenses				
194,080	208,184	14,104	6.8%	Salaries, Wages & Employee Benefits	614,216	626,920	12,704	2.0%
3,833	10,433	6,600	63.3%	Professional Fees	6,956	31,299	24,343	77.8%
86,925	76,551	(10,374)	(13.6%)	Purchased Services	182,910	229,653	46,743	20.4%
-	21,801	21,801	100.0%	Printing & Postage	2,814	65,403	62,589	95.7%
1,180	1,622	442	27.3%	Depreciation & Amortization	3,435	4,866	1,431	29.4%
6,753	12,437	5,684	45.7%	Other Operating Expenses	37,429	37,311	(118)	(0.3%)
13,434	18,092	4,658	25.7%	Indirect Cost Allocation, Occupancy	48,114	54,276	6,162	11.4%
306,203	**349,120**	**42,917**	**12.3%**	**Total Administrative Expenses**	**895,874**	**1,049,728**	**153,854**	**14.7%**
469,043	**164,902**	**304,142**	**184.4%**	**Change in Net Assets**	**1,976,616**	**349,422**	**1,627,194**	**465.7%**
86.0%	***90.3%***	(4.3%)		***Medical Loss Ratio***	***82.4%***	***91.2%***	(8.8%)	
5.5%	***6.6%***	***1.1%***		***Admin Loss Ratio***	***5.5%***	***6.6%***	***1.1%***	

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CalOptima Health
MSSP
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
546	**581**	(35)	(6.0%)	**Member Months**	**1,671**	**1,737**	(66)	(3.8%)
				Revenues				
224,537	259,320	(34,783)	(13.4%)	Medi-Cal Capitation Revenue	692,929	775,281	(82,352)	(10.6%)
224,537	**259,320**	(34,783)	(13.4%)	**Total Operating Revenue**	**692,929**	**775,281**	(82,352)	(10.6%)
				Medical Expenses				
148,052	213,799	65,747	30.8%	Medical Management	497,705	643,649	145,944	22.7%
17,944	34,119	16,175	47.4%	Waiver Services	57,810	102,357	44,547	43.5%
165,997	**247,918**	**81,921**	**33.0%**	**Total Program Expenses**	**555,516**	**746,006**	**190,490**	**25.5%**
58,540	**11,402**	**47,138**	**413.4%**	**Gross Margin**	**137,413**	**29,275**	**108,138**	**369.4%**
				Administrative Expenses				
116,958	117,343	385	0.3%	Salaries, Wages & Employee Benefits	342,584	353,450	10,866	3.1%
1,530	1,583	53	3.4%	Professional Fees	4,590	4,749	159	3.4%
2	-	(2)	(100.0%)	Purchased Services	5	-	(5)	(100.0%)
8,661	6,291	(2,370)	(37.7%)	Other Operating Expenses	24,153	18,873	(5,280)	(28.0%)
1,125	7,833	6,708	85.6%	Indirect Cost Allocation, Occupancy	16,785	23,499	6,714	28.6%
128,276	**133,050**	**4,774**	**3.6%**	**Total Administrative Expenses**	**388,116**	**400,571**	**12,455**	**3.1%**
(69,736)	(121,648)	**51,912**	**42.7%**	**Change in Net Assets**	(250,703)	(371,296)	**120,593**	**32.5%**
73.9%	***95.6%***	(21.7%)		***Medical Loss Ratio***	***80.2%***	***96.2%***	(16.1%)	
57.1%	***51.3%***	(5.8%)		***Admin Loss Ratio***	***56.0%***	***51.7%***	(4.3%)	

CalOptima Health
Covered California
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Capitation Revenue	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Medical Expenses				
-	168,365	168,365	100.0%	Medical Management	-	505,096	505,096	100.0%
-	**168,365**	**168,365**	**100.0%**	**Total Medical Expenses**	**-**	**505,096**	**505,096**	**100.0%**
-	(168,365)	**168,365**	(100.0%)	**Gross Margin**	**-**	(505,096)	**505,096**	(100.0%)
				Administrative Expenses				
435,636	624,747	189,111	30.3%	Salaries, Wages & Employee Benefits	1,048,388	1,877,464	829,076	44.2%
125,036	222,222	97,186	43.7%	Professional Fees	437,605	666,666	229,061	34.4%
209,057	265,851	56,794	21.4%	Purchased Services	352,758	747,573	394,815	52.8%
-	30,007	30,007	100.0%	Printing & Postage	-	90,021	90,021	100.0%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
11,116	4,354	(6,762)	(155.3%)	Other Operating Expenses	11,158	13,062	1,904	14.6%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
780,844	**1,147,181**	**366,337**	**31.9%**	**Total Administrative Expenses**	**1,849,909**	**3,394,786**	**1,544,877**	**45.5%**
(780,844)	(1,315,546)	**534,702**	**40.6%**	**Income (Loss) From Operations**	(1,849,909)	(3,899,882)	**2,049,973**	**52.6%**
				Non-Operating Income (Loss)				
(2)	-	2	100.0%	Other Income/Expense	(2)	-	2	100.0%
(780,846)	(1,315,546)	**534,700**	**40.6%**	**Change in Net Assets**	(1,849,911)	(3,899,882)	**2,049,971**	**52.6%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Building Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
93,991	29,814	(64,177)	(215.3%)	Purchased Services	280,675	89,442	(191,233)	(213.8%)
194,267	208,333	14,066	6.8%	Depreciation & Amortization	582,800	624,999	42,199	6.8%
21,938	23,583	1,645	7.0%	Insurance Expense	65,813	70,749	4,936	7.0%
21,241	305,563	284,322	93.0%	Repair & Maintenance	426,632	916,689	490,057	53.5%
109,832	61,231	(48,601)	(79.4%)	Other Operating Expenses	302,715	183,693	(119,022)	(64.8%)
(441,268)	(628,525)	(187,257)	(29.8%)	Indirect Cost Allocation, Occupancy	(1,658,635)	(1,885,575)	(226,940)	(12.0%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
130,366	130,249	117	0.1%	Building Income	422,022	390,747	31,275	8.0%
130,366	**130,249**	**117**	**0.1%**	**Total Operating Revenue**	**422,022**	**390,747**	**31,275**	**8.0%**
				Administrative Expenses				
67,414	13,350	(54,064)	(405.0%)	Purchased Services	204,714	40,050	(164,664)	(411.1%)
87,709	116,667	28,958	24.8%	Depreciation & Amortization	263,127	350,001	86,874	24.8%
7,972	8,417	445	5.3%	Insurance Expense	24,000	25,251	1,251	5.0%
69,493	174,314	104,821	60.1%	Repair & Maintenance	204,078	522,942	318,864	61.0%
35,132	32,319	(2,813)	(8.7%)	Other Operating Expenses	117,993	96,957	(21,036)	(21.7%)
(244,140)	(127,856)	116,284	90.9%	Indirect Cost Allocation, Occupancy	(301,316)	(383,568)	(82,252)	(21.4%)
23,581	**217,211**	**193,630**	**89.1%**	**Total Administrative Expenses**	**512,595**	**651,633**	**139,038**	**21.3%**
106,785	(86,962)	**193,747**	**222.8%**	**Change in Net Assets**	(90,573)	(260,886)	**170,313**	**65.3%**

CalOptima Health
Building 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2026

September 2026					July 2026 - September 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Building Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
36,770	3,333	(33,437)	(1003.2%)	Purchased Services	110,452	9,999	(100,453)	(1004.6%)
9,397	16,667	7,270	43.6%	Depreciation & Amortization	28,192	50,001	21,809	43.6%
4,984	4,724	(260)	(5.5%)	Insurance Expense	14,951	14,172	(779)	(5.5%)
744	47,868	47,124	98.4%	Repair & Maintenance	7,980	143,604	135,624	94.4%
924	12,454	11,530	92.6%	Other Operating Expenses	4,601	37,362	32,761	87.7%
52,820	**85,046**	**32,226**	**37.9%**	**Total Administrative Expenses**	**166,176**	**255,138**	**88,962**	**34.9%**
(52,820)	(85,046)	**32,226**	**37.9%**	**Change in Net Assets**	(166,176)	(255,138)	**88,962**	**34.9%**

OTHER PROGRAM INCOME STATEMENTS – SPETEMBER MONTH:

PACE

- **CHANGE IN NET ASSETS** is $0.5 million, favorable to budget $0.3 million

MSSP

- **CHANGE IN NET ASSETS** is ($69,736), favorable to budget $51,912

Covered CA

- **CHANGE IN NET ASSETS** is ($0.8) million, favorable to budget $0.5 million

NON-OPERATING INCOME STATEMENTS – SEPTEMBER MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is $0.1 million, favorable to budget $0.2 million

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($52,820), favorable to budget $32,226

INVESTMENT INCOME

- Net Investment Income/(Loss) of ($9.1) million due to $14.9 million in net interest income, offset by $24.0 million in unrealized loss on investments

CalOptima Health
Balance Sheet
September 30, 2026

	September-26	August-26	$ Change	% Change
ASSETS				
Current Assets				
Operating Cash	261,510,007	386,002,219	(124,492,212)	(32.3%)
Short-term Investments	1,858,175,339	1,725,622,247	132,553,092	7.7%
Receivables - Other	15,593,544	20,493,255	(4,899,711)	(23.9%)
Prepaid Expenses	43,845,945	24,603,925	19,242,020	78.2%
Capitation Receivables	583,450,343	605,914,116	(22,463,773)	(3.7%)
Total Current Assets	**2,762,575,178**	**2,762,635,762**	(60,584)	(0.0%)
Total Capital Assets, Net	**127,388,730**	**125,804,811**	**1,583,918**	**1.3%**
Other Assets				
Net Assets Liabilities	4,069,081	4,069,081	-	0.0%
Restricted Deposit	300,000	300,000	-	0.0%
Total Other Assets	**4,369,081**	**4,369,081**	**-**	**0.0%**
Board Designated Assets				
Board Designated Reserves	1,632,666,074	1,643,348,180	(10,682,106)	(0.7%)
Statutory Designated Reserves	155,188,633	141,775,715	13,412,918	9.5%
Total Designated Assets	**1,787,854,707**	**1,785,123,895**	**2,730,812**	**0.2%**
TOTAL ASSETS	**4,682,187,696**	**4,677,933,550**	**4,254,146**	**0.1%**
Deferred Outflows				
GASB 68 - PERS - Contributions	1,886,033	1,886,033	-	0.0%
GASB 68 - PERS - Difference in Experience	24,960,547	24,960,547	-	0.0%
GASB 68 - PERS - Changes in Assumptions	3,079,433	3,079,433	-	0.0%
GASB 75 - OPEB - Contributions	721,000	721,000	-	0.0%
GASB 75 - OPEB - Changes in Assumptions	276,000	276,000	-	0.0%
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,713,110,709**	**4,708,856,563**	**4,254,146**	**0.1%**

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CalOptima Health
Balance Sheet
September 30, 2026

	September-26	August-26	$ Change	% Change
LIABILITIES				
Current Liabilities				
Accounts Payable	221,073,714	176,979,538	44,094,176	24.9%
Accrued Payroll Liabilities	30,015,794	26,601,685	3,414,108	12.8%
Deferred Revenue	5,851,767	5,921,439	(69,671)	(1.2%)
Due to State of California and CMS	703,762,892	759,547,493	(55,784,601)	(7.3%)
Medical Claims Liabilities				
Consolidated	1,035,881	368,513	667,368	181.1%
Medi-Cal	332,094,530	324,464,744	7,629,786	2.4%
MSSP	-	-	-	0.0%
OneCare Connect	4,065,700	4,065,700	-	0.0%
OneCare	17,083,935	19,261,548	(2,177,613)	(11.3%)
PACE	3,553,383	3,783,730	(230,348)	(6.1%)
Medical Claims Liabilities	357,833,429	351,944,235	5,889,194	1.7%
Capitation and Withholds	137,476,993	132,011,238	5,465,755	4.1%
Total Current Liabilities	**1,456,014,589**	**1,453,005,628**	**3,008,961**	**0.2%**
GASB 96 Subscription Liabilities	32,023,336	32,130,090	(106,754)	(0.3%)
Capital Lease Payable	183,953	188,230	(4,277)	(2.3%)
Community Reinvestment, Capital Lease Payable	64,997,176	66,147,226	(1,150,050)	(1.7%)
Post Employment Health Benefits Liability	15,837,052	15,812,489	24,562	0.2%
Net Pension Liabilities	-	-	-	0.0%
TOTAL LIABILITIES	**1,569,056,106**	**1,567,283,664**	**1,772,442**	**0.1%**
Deferred Inflows				
GASB 68 - PERS - Difference in Experience	889,598	889,598	-	0.0%
GASB 68 - PERS - Difference in Earnings	13,474,595	13,474,595	-	0.0%
GASB 75 - OPEB - Changes in Assumptions	449,000	449,000	-	0.0%
GASB 75 - OPEB - Difference in Experience	1,910,000	1,910,000	-	0.0%
GASB 53 - INVT - Changes in Fair Value	-	-	-	0.0%
Required TNE	151,766,779	135,040,486	16,726,293	12.4%
Funds in excess of TNE	2,975,564,631	2,989,809,220	(14,244,589)	(0.5%)
Net Assets	**3,127,331,410**	**3,124,849,706**	**2,481,704**	**0.1%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION	**4,713,110,709**	**4,708,856,563**	**4,254,146**	**0.1%**

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BALANCE SHEET – SEPTEMBER MONTH:

ASSETS of $4.7 billion increased $4.3 million from August or 0.1%

- Prepaid expenses increased $19.2 million due to the advancement of prepaid CY 2025 Hospital Quality Assurance Fee (HQAF) funding of $15.0 million
- Operating Cash and Short-term Investments increased $8.1 million due month-end cut-off and payment timing
- Total Revenue Receivables decreased $22.5 million due to adjustments related to the CY 2025 rate change, including both Managed Care Organization (MCO) tax and base capitation rates
- Other Receivables decreased $4.9 million

LIABILITIES of $1.6 billion increased $1.8 million from August or 0.1%

- Accounts Payable increased $44.1 million due to the MCO tax accrual
- Medical Claims Liabilities increased $5.9 million due to variability in claims experience
- Capitation and Withholds increased $5.5 million
- Due to State of California and the Centers for Medicare & Medicaid Services (CMS) decreased $55.8 million due to release of accruals relating to updated CY 2025 population acuity estimates of $38.2 million and MCO tax of $15.1 million, based on the final CY 2025 rates received in September

NET ASSETS of $3.1 billion, increased $2.5 million from August or 0.1%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of September 30, 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	815,335,413				
MetLife Tier One	817,330,660				
Board Designated Reserves	1,632,666,074	1,154,279,662	1,846,847,459	478,386,411	(214,181,386)
Current Reserve Level (X months of average monthly revenue) [1]	*3.54*	*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	77,666,204				
MetLife Tier Two	77,522,429				
Statutory Designated Reserves	155,188,633	151,766,779	166,943,457	3,421,854	(11,754,823)
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 Flow
September 2026

	September 2026	July - September 2026
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,481,704	12,199,939
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,548,854	4,703,565
Changes in assets and liabilities:		
Prepaid expenses and other	(19,242,020)	(28,828,387)
Capitation receivable	27,363,484	31,008,433
Medical claims liability	5,889,194	(4,646,047)
Deferred revenue	(69,671)	(69,671)
Payable to health networks	5,465,755	12,203,920
Accounts payable	44,094,176	(4,593,060)
Accrued payroll	3,438,670	(3,078,332)
Other accrued liabilities	(57,045,682)	(93,207,607)
Net cash provided by/(used in) operating activities	13,924,463	(74,307,248)
GASB53, GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES:		
Change in Investments	(132,553,092)	1,902,502
Change in Property and Equipment	(3,132,772)	(21,821,900)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	-	-
Change in Homeless Health Reserve	(2,730,812)	(9,299,790)
Net cash provided by/(used in) investing activities	(138,416,675)	(29,219,188)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	(124,492,212)	(103,526,436)
CASH AND CASH EQUIVALENTS, beginning of period	386,002,219	365,036,442
CASH AND CASH EQUIVALENTS, end of period	**261,510,007**	**261,510,007**

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CalOptima Health
Spending Plan
For the Three Months Ending September 30, 2026

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @9/30/2026	**$3,127.3**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,632.7**			**52.2%**
Statutory Designated Reserve[1]	**$155.2**			**5.0%**
Capital Assets, net of Depreciation	**$127.4**			**4.1%**
Resources Allocated				
Homeless Health Initiative[2]	13.9	63.3	49.4	0.4%
Housing and Homelessness Incentive[2]	26.6	87.4	60.8	0.8%
Intergovernmental Transfers (IGT)	34.2	52.1	17.9	1.1%
Digital Transformation and Workplace Modernization[3]	18.9	100.0	81.1	0.6%
CalFresh and Redetermination Outreach Strategy	1.5	6.0	4.5	0.0%
Coalition of Orange County Community Health Centers Grant	10.7	50.0	39.3	0.3%
General Awareness Campaign	0.0	4.7	4.7	0.0%
Member Health Needs Assessment	0.3	1.3	1.1	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	100.3	153.5	53.2	3.2%
Skilled Nursing Facility Access Program	10.0	10.0	-	0.3%
National Alliance for Mental Illness Orange County Peer Support Program Grant	1.5	5.0	3.5	0.0%
Stipend Program for Master of Social Work Students Grant	-	5.0	5.0	0.0%
Wellness & Prevention Program Grant	0.7	2.7	2.0	0.0%
CalOptima Health Provider Workforce Development Fund Grant	17.5	30.1	12.6	0.6%
Garden Grove Bldg. Improvement	16.0	17.5	1.6	0.5%
Dyadic Services Program Academy	0.2	1.9	1.7	0.0%
Medi-Cal Provider Rate Increases (07/2024 - 12/2026)	52.6	526.2	473.6	1.7%
Medi-Cal Provider Rate Increases (07/2026 - 12/2028)	386.6	429.6	43.0	12.4%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.0	0.3	0.2	0.0%
Medi-Cal Eligibility Outreach Strategy	19.8	21.8	2.0	0.6%
Supplemental Food Support for Medi-Cal Members	3.8	8.0	4.2	0.1%
Orange County Community Health Assessment and Improvement Plan	0.5	1.0	0.5	0.0%
PACE Facility - Irvine	28.7	29.5	0.9	0.9%
Subtotal	**744.2**	**1,607.1**	**862.9**	**23.8%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$467.9**			**15.0%**

[1]Total Designated Reserves and unallocated reserve amount can support approximately 176 days of CalOptima Health's current operations.

[2]See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3]On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

CalOptima Health
Key Financial Indicators
As of September 30, 2026

	Item Name	September 2026					July 2026 -September 2026				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	788,667	766,499	22,168	2.9%		2,384,838	2,322,475	62,363	2.7%	
	Operating Revenue	1,029,431,604	368,664,341	660,767,263	179.2%		1,793,156,336	1,115,592,105	677,564,231	60.7%	
	Medical Expenses	996,414,869	352,570,986	(643,843,883)	(182.6%)		1,725,862,138	1,076,620,460	(649,241,678)	(60.3%)	
	General and Administrative Expense	22,127,773	25,303,644	3,175,871	12.6%		65,826,781	76,047,803	10,221,022	13.4%	
	Non-Operating Income/(Loss)	(8,407,258)	8,161,323	(16,568,581)	(203.0%)		10,732,522	24,483,969	(13,751,447)	(56.2%)	
	Summary of Income & Expenses	2,481,704	(1,048,966)	3,530,670	336.6%		12,199,939	(12,592,189)	24,792,128	196.9%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated MLR	96.8%	95.6%	1.2%			96.2%	96.5%	(0.3%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated ALR	2.1%	6.9%	4.7%			3.7%	6.8%	3.1%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@9/30/2026	3,610,925,473	3,480,860,904	130,064,568	3.7%

Unallocated/Unassigned Reserve Balance	Current Month @September 2026	Fiscal Year Ending June 2026	Change	%
Consolidated	467,863,345	357,469,971	110,393,374	30.9%
*Days Cash On Hand**	176			

*Total Designated Reserves and unallocated reserve amount can support approximately 176 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 Three Months Ending September 30, 2026

	September 2026				July - September 2026				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**421,798**	**895,500**	**473,702**	**52.9%**	**1,111,927**	**895,500**	**(216,427)**	**(24.2%)**	**18,856,055**	**18,781,035**	**(75,020)**	**(0.4%)**
Operating Expenses:												
Salaries, Wages & Benefits	-	-	-	0.0%	-	-	-	0.0%	17,826,058	17,826,058	-	0.0%
Professional Fees	255,948	283,333	27,385	9.7%	255,948	849,999	594,051	69.9%	10,660,021	11,254,072	594,051	5.3%
Purchased Services	-	-	-	0.0%	-	-	-	0.0%	1,190,915	1,190,915	-	0.0%
GASB 96 Amortization Expenses	-	-	-	0.0%	-	-	-	0.0%	2,563,169	2,563,169	-	0.0%
Other Expenses	28,784	166,667	137,883	82.7%	86,351	500,001	413,650	82.7%	25,929,008	26,342,658	413,650	1.6%
Medical Management	-	-	-	0.0%	-	-	-	0.0%	5,502,156	5,502,156	-	0.0%
Total Operating Expenses	**284,732**	**450,000**	**165,268**	**36.7%**	**342,299**	**1,350,000**	**1,007,701**	**74.6%**	**63,671,327**	**64,679,028**	**1,007,701**	**1.6%**

Funding Balance Tracking: July 2025	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	28,715,951	18,856,055	9,859,896
FY2023 Operating Budget	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	23,951,502	23,951,502	-
FY2026 Operating Budget	8,208,424	8,208,424	-
FY2027 Operating Budget	5,400,000	342,299	5,057,701
Ending Funding Balance	**2,555,020**	**17,472,616**	**14,917,597**
Add: Prior year unspent Operating Budget	-		
Total available Funding	**2,555,020**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets
[2] Unspent budget from this period is added back to available DTS funding
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of September 30, 2026

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	61,496,005	61,496,005	49,417,870	12,078,135	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**103,396,005**	**103,396,005**	**49,417,870**	**53,978,135**	**-**

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[6]	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)[4]	-	-	-	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	10,000,000	-	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support[5]	925,540	925,540	-	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	5,104,626	4,784,287	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[3]	14,279,077	9,909,215	4,369,862	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**103,396,005**	**49,417,870**	**53,978,135**	
Transfer of funds to HHIP[4]	(40,100,000)	-	(40,100,000)	
Program Total	**63,296,005**	**49,417,870**	**13,878,135**	

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

[2]On June 5, 2025, CalOptima Health's Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program ($3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board action), to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[4]On February 5, 2026, CalOptima Health's Board of Directors approved the closeout of the Day Habilitation (County for HomeKey) and designated the remaining balance of $2.5 million as available for allocation to deliver enhanced services for Medi-Cal members.

[5]On April 2, 2026, CalOptima Health's Board of Directors approved the closeout of the CalOptima Days, HCAP and FQHC Administrative Support and make $37,721 in IGT 8 funds available toward future IGT initiatives to deliver covered services for Medi-Cal members.

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of September 30, 2026

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	65,931,189	65,931,189	35,095,097	30,836,093	-
Existing Reserves & HHI Transfer	87,384,530	87,384,530	60,820,559	26,563,971	-
Street Medicine Support Center - GG Building[2]	7,000,000	7,000,000	-	7,000,000	-
Total	**160,315,719**	**160,315,719**	**95,915,656**	**64,400,064**	-

Funds Allocation, Approved Initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,056,488	2,056,488	-	HHI
Pulse For Good	1,400,000	917,350	482,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,821,311	800,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,832,310	4	HHI
Capital Projects	135,997,542	72,303,100	63,694,442	HHI & Existing Reserves
System Change Projects	16,214,530	10,329,707	5,884,823	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**166,822,185**	**$95,915,656**	**$70,906,529**	
Transfer of funds to Street Medicine Support Center-GG Building	**(7,000,000)**	**-**	**($7,000,000)**	Existing Reserves
Program Total	**159,822,185**	**95,915,656**	**63,906,529**	

[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

[2]On October 7, 2025, CalOptima Health's Board of Directors approved up to $7.0 million for general contractor services & furniture, fixtures & equipment for the Street Medicine Support Center

CalOptima Health
Fiscal Year 2026-27 Budget Allocation Changes
Reporting Changes as of September 30, 2026

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	IT - Clinical Technology - Professional Fees - Managed Services	IT - Clinical Technology - Maintenance HW/SW	$177,000	For Referral Platform
July	Medi-Cal	Communications - Consulting - Website Content and Media Outreach	Communications - Advertising - Equity and Community Health Campaign	$35,000	For Advertising Costs
July	Medi-Cal	Human Resources - Consulting - Employee Engagement	Human Resources - Training & Seminars	$60,000	For Training
July	Medi-Cal	Human Resources - Purchased Services - LiveScan Fingerprinting	Human Resources - Training & Seminars	$25,000	For Training
July	Medi-Cal	IT - Applications Management - Other Operating Expenses	IT - Applications Management - Professional Fees	$90,000	For Consulting
August	Covered California	Behavorial Health - Training & Seminars	Behavorial Health - Consulting	$15,000	For Consulting
September	Covered California	Communications - Professional Fees - Campaign Development	Communications - Purchased Services - Digital Advertising	$49,900	For Advertising Costs
September	Medi-Cal	Information Security - Professional Fee - Gartner Subscription	Information Security - Other Admin - Priviledged Access Management	$23,402	For Licenses

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting October November 5, 2026

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 updates, and any notices of non-compliance or enforcement action issued by regulators.

A. UPDATES ON REGULATORY AUDITS

1. Medicare

a. Calendar Year (CY) 2020 Part C Risk Adjustment Data Validation (RADV) Audit (CON20 RADV) *(applicable to OneCare)*

Update

- ***None.***

Previously Reported

- 3/20/26 – Contract selection notification received.
- Below are the key dates for the audit:
  - Enrollee Data List Available: 4/3/26
  - Medical record submission window Opens: 4/13/26
  - Medical record submission deadline: 8/28/26
  - Hardship exception request deadline: 9/11/26
- 4/3/26 – Enrollee Data list received; 35 enrollees selected.
- Medical records have been reviewed, validated and submitted to Centers for Medicare & Medicaid (CMS). Awaiting review and audit results from CMS.

Background

- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2020 risk adjustment data and payments associated with encounters with dates of service from January 1, 2019, through December 31, 2019.

b. Calendar Year (CY) 2021 Park C Risk Adjustment Data Validation (RADV) Audit (CON21 RADV) (applicable to OneCare)

Update

- Medical records are being reviewed, validated and submitted to CMS, and this process will continue until the submission window closes on 11/6/26.

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Previously Reported

- 5/29/26 – Contract selection notification received.
- 6/12/26 – Enrollee Data list received; 35 enrollees selected.
  - Medical record submission window opens: 6/22/26
  - Medical record submission deadline: 11/6/26
  - Hardship exception request deadline: 11/20/26

Background

- CMS will be conducting a medical records review to validate the accuracy of a subset of PY 2021 risk adjustment data and payments associated with encounters with dates of services from January 1, 2020 through December 31, 2020.

c. Calendar Year (CY) 2024 Part C Risk Adjustment Data Validation (RADV) Audit (CON24 RADV) (applicable to OneCare)

Update

- 8/31/26 – Contract selection notification received.
- 9/11/26 – Enrollee Data list received; 35 enrollees selected.
  - Medical record submission window opens: 9/18/26
  - Medical record submission deadline: 2/3/27
  - Hardship exception request deadline: 2/19/27

Background

- CMS will be conducting a medical records review to validate the accuracy of a subset of PY 2024 risk adjustment data and payments associated with encounters with dates of services from January 1, 2023 through December 31, 2023.

d. 2026 Department of Health Care Services (DHCS) PACE Audit

Update

- ***None.***

Previously Reported

- 2/19/26 – Audit engagement letter received.
- DHCS onsite conducted 4/20/26-4/21/26. Additional documents were requested during the onsite review.
- 4/23/26 – All requested documents were submitted.
- 5/14/26 – Exit conference held.
- Six preliminary findings and two areas of concern were noted. Internal corrective action plans were issued to address the preliminary findings while awaiting DHCS' audit report.
- Awaiting Final Audit Report. Remediation underway.

Background

- DHCS will conduct a routine review of CalOptima Health's PACE program. The following areas are included in the scope of the review: grievance documentation procedures; participant records for clinical appropriateness and care planning; transportation; personnel records; subspecialty subcontractor agreements; serious incident reports; onsite facility review; emergency preparedness; and meal preparation and kitchen procedures.
- DHCS conducts this audit every three years on the PACE program.

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e. Annual Compliance Program Effectiveness (CPE) Audit (*applicable to OneCare*)

Update

- 9/14/26 - Pre-audit deliverables submitted.
- 9/17/26 – Sample selections received. Four cases, one from each program area selected.
- Practice sessions with the consultant were held throughout the week of 9/21-9/24.
- Audit webinar week: 10/5/26 – 10/8/26
  - Closing conference will be held on10/8/26.

Previously reported

- Kick-off meeting held on 8/4/26
- Independent consultant conducted two pre-training sessions with CalOptima Health (8/6/26 and 8/12/26).
- Audit webinar week: 10/5/26 – 10/9/26
- RAC Medicare requested the business areas to submit the pre-audit deliverables

Audit engagement letter received on 8/24/26.Background:

- CalOptima Health is required to conduct an independent audit of the effectiveness of its Compliance program annually 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 outlined in the CMS Medicare Part C and D Program Audit Protocols.
- The audit will start in early August and continue through November 2026.
- The audit review period will be from 2/2/26 through 7/31/26.

2. Medi-Cal

a. CY 2026 DHCS Medical Audit*

** DHCS has revised the audit nomenclature to reflect a Calendar Year (CY) lookback period. Under the prior nomenclature, this would have been named CY2027 DHCS Medical Audit.*

- October 2, 2026 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit will consist of an evaluation of CalOptima Health's compliance with its contract and regulations in six (6) categories:
    1. Utilization Management (UM)
    2. Case management and coordination of care
    3. Availability and accessibility
    4. Member's rights
    5. Quality management
    6. Administrative and organizational capacity
- The audit will involve a review of pre-onsite documents, staff interviews and medical record review.
- Onsite interviews will be conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.

- **Key Dates and Information:**
  - **Entrance Conference scheduled for**: 1/11/27
  - **Interview dates**: 1/11/27 – 1/22/27 (all interviews to be conducted virtually))

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- **Delegate Selected to Participate**: CHOC (UM-focus only)
- **Lookback period**: 1/1/26 – 12/31/26
- **Pre-onsite Documents Due to DHCS:** 11/30/26

b. 2026 Department of Health Care Services (DHCS) Annual Routine Medical Audit

Update

- On 10/1/26, CalOptima Health provided its timely CAP update to DHCS. CalOptima Health awaits DHCS's response. All CAPs remain open.
- CalOptima Health's Regulatory Affairs and Compliance (RAC) Medi-Cal team will continue working with DHCS and internal business areas to ensure CAP milestones are met and the CAP is successfully closed.

Previously Reported

- On 7/17/26, CalOptima Health received the final audit report for the Calendar Year (CY) 2025 DHCS Medical Audit. **There was no increase in the number of findings from the draft report; the total remains at 4.**
- The final audit reports cover DHCS's review of both the Primary (aka "Main Contract") and Secondary (aka "State Supported Services") contracts. The findings are as follows:
  - **Primary/Main Contract:** Final audit report identified **4 Findings** across 2 audit categories.

Category #	Audit Area	# of Findings
1	Utilization Management	0
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	2

  - **Secondary Contract - State Supported Services (SSS)**
    - Final Report Identified **No Findings**
- 7/27/26, CalOptima Health received the formal request for corrective action (CAP). The CAP is due to DHCS on 8/26/26.
- RAC Medi-Cal has met with the impacted business areas and confirmed remedial efforts are complete or underway. RAC Medi-Cal anticipates a timely CAP submission.
- On 8/26/26, CalOptima Health submitted its timely CAP response to DHCS.
- On 9/3/26, DHCS replied, accepting several actions and requesting additional documentation for others. All four CAPs remain open.

B. REGULATORY NOTICES OF NON-COMPLIANCE

- CalOptima Health did not receive any notices of non-compliance from its regulators in September 2026.

C. UPDATES ON HEALTH NETWORK MONITORING AND AUDITS

- 2026 Delegation Oversight Annual Audit (DOAA):
  - Noble Mid-Orange County – Lookback: July 1, 2025 to June 30, 2026 (Annual Audit webinar

,
week September 21, 2026 to September 25, 2026)

D. INTERNAL AUDIT DEPARTMENT (IAD)

a. Internal Audits in Planning

- Pharmacy Department and PBM (Part D)
- PACE (Medi-Cal and OneCare)

b. Internal Audits in Process

- 2026 Claims Payment Integrity and Systems Controls Audit
- 2026 Case Management (OneCare)
- 2026 Utilization Management (Medi-Cal)
- 2026 CalAIM Community Supports Personal Care Homemaker Services

c. Internal Audits Completed (in past 60 days)

- 2025 CalAIM Community Supports Housing Transition Navigation Services – completed 7/22/2026
- 2026 Grievances and Appeals (Medi-Cal) – completed 7/16/2026
- 2026 Case Management (Medi-Cal) – completed 9/15/2026

d. Grant Reviews In Process

- Mind OC Irvine Hub Campus (Non-Cal AIM grant)
- Dayle McIntosh Center (2023 Incentive Payment Program (IPP) Grant)
- Children's Hospital Los Angeles (2023 ECM Academy Cohort 2 Grant)
- Maximon Behavioral Health, dba Mindful Living Center LLC (2023 ECM Academy Cohort 2 Grant)
- Global Transitional Care, Inc. dba Care Partners (2023 ECM Academy Cohort 2 Grant)

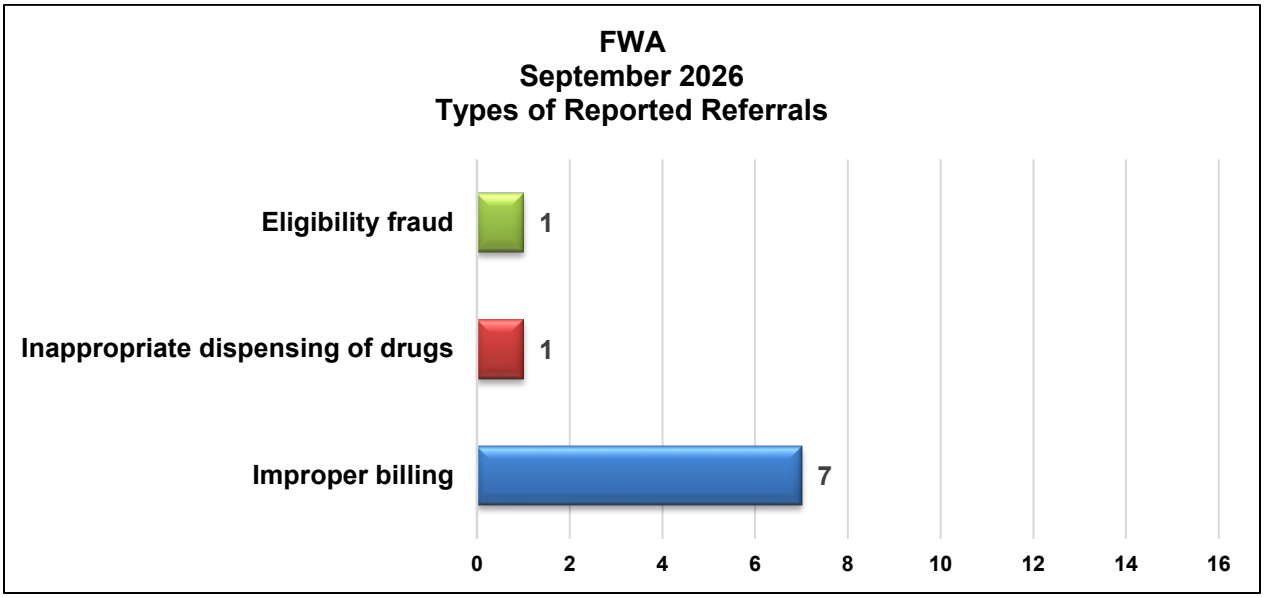
e. Grant Reviews Completed (in the past 60 days)

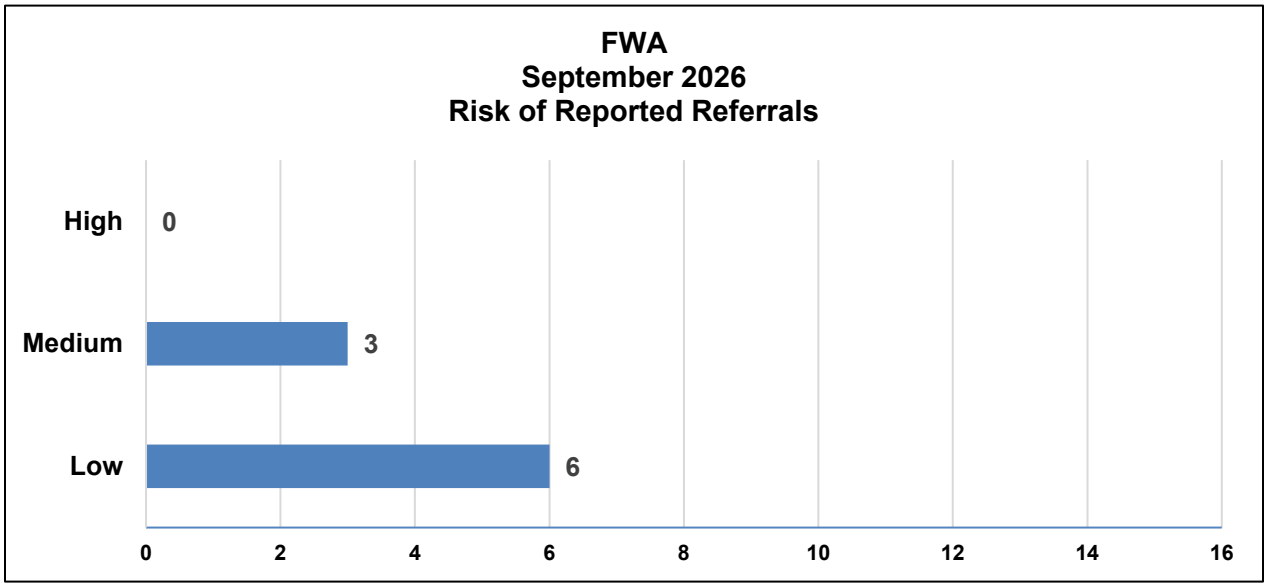
- Coalition of Orange County Community Health Centers, Population Health Value-Based Care (PHVBC) Grant – Interim Review, Year 3
- April Parker Foundation (2023 ECM Academy Cohort 2 Grant)
- Casa de la Familia (2023 ECM Academy Cohort 2 Grant)
- Central County Senior Services, LLC, dba Alzheimer's Orange County (2023 ECM Academy Cohort 2 Grant)
- Mariposa Women & Family Center (2023 ECM Academy Cohort 2 Grant)
- Mercy Housing California (Housing and Homelessness Incentive Program (HHIP) Capital Grants)
- Jamboree Housing (HHIP Capital Grants)
- Optum – Arta (2022 Initial CalAIM ECM IPP Payment)
- Optum – Monarch (2022 Initial CalAIM ECM IPP Payment)
- Optum – Talbert (2022 Initial CalAIM ECM IPP Payment)

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E. FRAUD, WASTE & ABUSE (FWA) INVESTIGATIONS



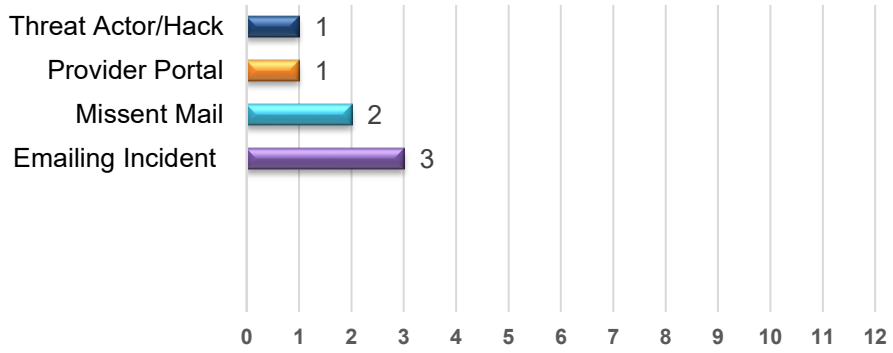


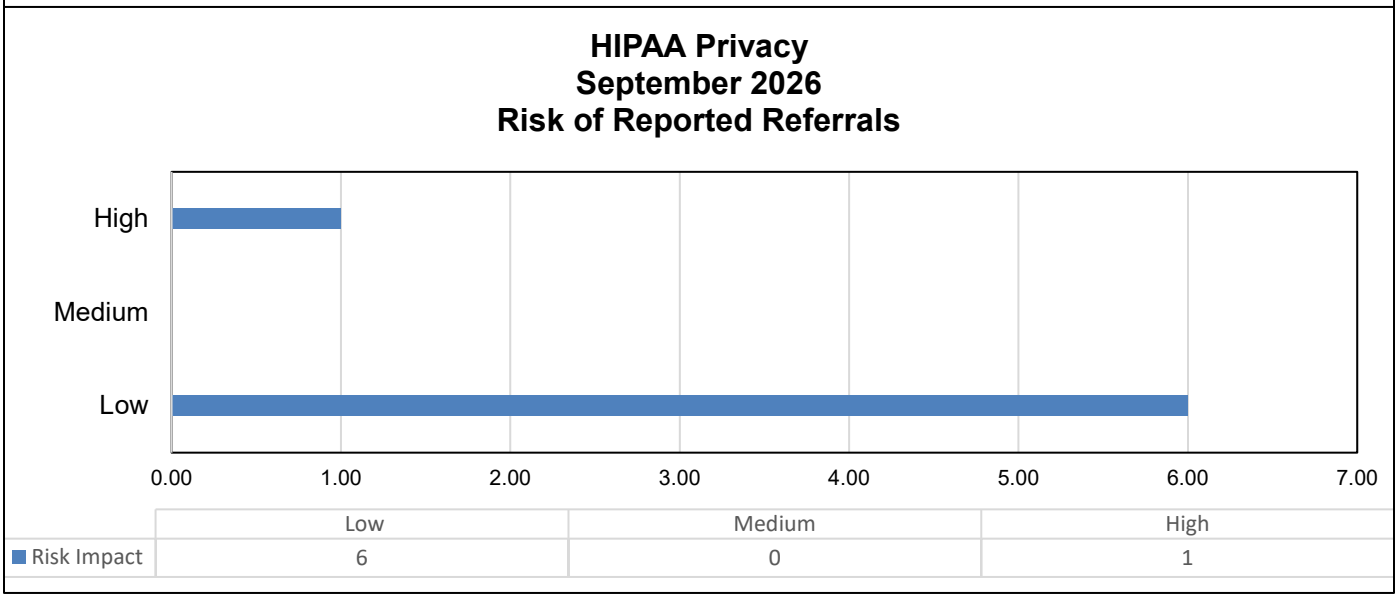
Number of New Cases Referred to DHCS and DOJ (State)	9
Number of New Cases Referred to CMS (Federal)	4
Total Number of Referrals Reported	**9**

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F. PRIVACY UPDATE





Total Number of Referrals Reported to DHCS (State)	7
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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VAN SCOYOC ASSOCIATES

Date: **October 23, 2026**

To: **Board of Directors**
CalOptima Health

From: **Shawn Friesen, Vice President**
Van Scoyoc Associates

Re: **CalOptima Health, Board of Directors – November Advocacy Report**

CalOptima Health Holds Three Days of Capitol Hill Meetings During ACAP Visit

Van Scoyoc Associates (VSA) coordinated congressional meetings for CalOptima Health's September 29–October 1 visit to Washington, D.C., which took place as CalOptima Health team members traveled to Washington for conferences hosted by the Association for Community Affiliated Plans (ACAP). CalOptima Health participants included Jordan Abushawish, Senior Director, Federal and Local Government Affairs; Donovan Higbee, Senior Director, Public Policy; and Donna Laverdiere, Executive Director, Strategic Development. Discussions with congressional offices focused on CalOptima Health's resources and preparations for H.R. 1 implementation, particularly community engagement requirements, more frequent eligibility checks, and maintaining coverage for eligible members. In total, CalOptima Health met with 16 congressional offices over three days. Meetings included the following congressional offices representing Orange County in Congress:

- Senator Adam Schiff (D-CA)
- Representative Linda Sánchez (D-CA-38)
- Representative Young Kim (R-CA-40)
- Representative Derek Tran (D-CA-45)
- Representative Lou Correa (D-CA-46)
- Representative Dave Min (D-CA-47)
- Representative Mike Levin (D-CA-49)

(Note: A scheduled meeting with staff for Senator Alex Padilla (D-CA) was canceled at the last minute because of staff illness.)

Beyond Orange County, meetings included the offices of Representatives Vince Fong (R-CA-20), David Valadao (R-CA-22), Raul Ruiz (D-CA-25), Pete Aguilar (D-CA-33), Ken Calvert (R-CA-41), and Robert Garcia (D-CA-42). CalOptima Health also met with advisors to Senate Finance Committee Chairman Mike Crapo (R-ID), House Energy and Commerce Committee Chairman Brett Guthrie (R-KY), and Ranking Member Frank Pallone (D-NJ), broadening engagement with the committees responsible for Medicaid and Medicare policy.

Outreach to the Orange County Delegation and Beyond Continues

VSA continued outreach to congressional offices regarding CalOptima Health's advocacy priorities, programs, and community activities. Following CalOptima Health's meetings on Capitol Hill, VSA sent the offices background materials, information on CalOptima Health's preparations to implement community engagement requirements and other aspects of H.R. 1, and updated congressional district data sheets for offices representing portions of Orange County in the U.S. House of Representatives. VSA also shared CalOptima Health's Medi-Cal Changes Toolkit, October Community Update, and information regarding various CalOptima Health events in different congressional districts around Orange County. Engagement with California's Senate offices and offices outside Orange County also continued.

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VSA Meets with Senior CMCS Leadership on Medicaid Policy

On September 25, VSA Vice President Shawn Friesen met with senior leadership at the Center for Medicaid and CHIP Services (CMCS), the CMS office responsible for federal Medicaid and Children's Health Insurance Program (CHIP) policy. The meeting provided an opportunity to seek updates on implementation of Medicaid policy changes, the Administration's approach to Medicaid waivers, and other developments relevant to CalOptima Health.

CMS Defers an Additional $1.2 Billion in Federal Medicaid Payments to California

On October 20, Centers for Medicare & Medicaid Services (CMS) Administrator Mehmet Oz announced at the White House that CMS was deferring an additional $1.2 billion in Medicaid payments to California, citing concerns about personal care services. In its letter to the Department of Health Care Services (DHCS), CMS detailed over $1.26 billion in deferred federal payments for expenditures reported for the quarter ending June 30, 2026. The total includes approximately $1.118 billion in medical assistance and $143.8 million in administrative expenditures. About $1.086 billion relates to Community First Choice and personal care services, with CMS questioning spending growth, payroll taxes, sick leave, documentation, and billing patterns. Nine of the ten deferral categories repeated previously raised concerns, and CMS cited instances in which California has not responded to requests for information. Only $258,682 is specifically identified as managed care eligibility discrepancies; the letter does not name CalOptima Health or any Medicaid managed care organization. The action withholds federal reimbursement pending documentation and review. DHCS has 60 days from receipt to provide supporting documentation and may request up to 60 additional days.

DOJ Announces Medicaid, Other Health Care Fraud Charges in Southern California

On October 22, the Department of Justice (DOJ) announced charges in multiple health care fraud cases in Southern California. The announcement cited approximately $2 billion in alleged fraudulent claims, covering separate cases involving private insurance, Medicare, and Medi-Cal. The largest case involves more than $1.6 billion in substance-use treatment claims billed to private insurers. The Medi-Cal case involves the Medi-Cal Rx pharmacy benefit. Prosecutors allege that the charged individuals exploited the temporary suspension of prior authorization requirements during the transition to Medi-Cal Rx to submit approximately $269 million in fraudulent claims, of which approximately $179 million was paid. No Medi-Cal managed care plans are named or accused of wrongdoing in the announcement.

Federal Program Integrity Efforts Expand in Congress and the Administration

On September 29, House Energy and Commerce Committee Republicans released a 14-bill program integrity package, alongside a report containing 13 findings and 37 recommendations. Proposals address Medicaid data analytics, provider screening, state fraud risk assessments, home- and community-based services oversight, and incentives for states to recover improper payments. Of particular relevance to health plans, the package includes a proposal to expand Recovery Audit Contractor requirements to Medicaid managed care payments.

HHS Delegates Provider Exclusion Authority to CMS

On October 14, HHS published a notice delegating to CMS statutory authority to impose permissive exclusions on providers and suppliers from Medicare, Medicaid, and other federal health care programs for fraud and other grounds specified in law. The underlying law is unchanged, and the HHS Office of Inspector General's existing exclusion authority remains in place.

CMS Proposes Medicare Advantage and Part D Changes

On October 16, CMS released a proposed rule implementing provisions of the Consolidated Appropriations Act of 2026. The proposal would reduce the generic drug copayment from $1 to $0 for full-benefit dual eligible individuals at or below 100 percent of the federal poverty level beginning in 2028. It would also establish Medicare Advantage provider directory verification and accuracy requirements beginning in 2028, with public reporting of accuracy scores beginning in 2029, and cost-sharing protections for enrollees who rely on inaccurate directories. Additional provisions address pharmacy benefit manager compensation, reporting, and disclosure of certain manufacturer agreements. The proposal is relevant to

OneCare's network information, pharmacy arrangements, and member cost sharing. Comments are due 60 days after Federal Register publication, and CMS anticipates issuing its separate annual Medicare Advantage and Part D proposed rule later this fall.

CMS Issues Guidance on Optional CCBHC State Plan Benefit

CMS issued guidance on October 6 outlining how states may elect the optional Medicaid state plan benefit for Certified Community Behavioral Health Clinic (CCBHC) services outside the existing demonstration. States must certify clinics under federal criteria and cover nine core services, including crisis care, mental health and substance use disorder treatment, and intensive case management. Services may be delivered through fee-for-service or managed care. Unlike the demonstration, the state plan option does not provide an enhanced federal match or require a prospective payment system.

Senate Democrats Release Report on For-Profit Medicaid Contractors

On October 20, Senate Finance Committee Ranking Member Ron Wyden (D-OR) and Senators Elizabeth Warren (D-MA) and Raphael Warnock (D-GA) released a report examining five companies that support state Medicaid eligibility and enrollment systems: Maximus, Gainwell, General Dynamics Information Technology, Conduent, and Deloitte. The report raises concerns about a lack of contractor transparency and the potential for eligible beneficiaries to lose coverage as states implement H.R. 1's community engagement requirements and other eligibility changes. The report recommends that CMS strengthen contractor accountability through mandatory contract terms, financial penalties for wrongful disenrollments, independent audits, and public disclosure of contracts and performance data.

Senate Democrats Seek Input on Long-Term Care Reform

Senate Finance Committee Ranking Member Ron Wyden (D-OR) released an October 16 request for information on long-term care reform, with written responses due December 18. The request addresses affordable access to home care, nursing home quality, and the long-term care workforce, including potential coverage expansions, staffing standards, direct care worker compensation, and support for family caregivers. It is part of Senate Democrats' development of a broader health policy agenda. VSA shared the request and follow-up materials from committee staff with CalOptima Health. The process could offer CalOptima Health an opportunity to inform policy discussions by sharing its experience serving older adults and individuals with disabilities.

Senate Committee Advances HHS Nominees

On September 30, the Senate Health, Education, Labor, and Pensions Committee advanced Nicole Saphier's nomination to be Surgeon General, Timothy Westlake's nomination to be Assistant Secretary for Mental Health and Substance Use, and Mary Lazare's nomination to be Assistant Secretary for Aging. The nominees were approved together on a 12–11 party-line vote, with possible Senate floor consideration during the post-election session.

Year-End Funding and Health Policy Outlook Remain Uncertain

Congress is set to return after the November 3 elections facing a compressed agenda and a December 11 deadline for government funding. Some lawmakers are pressing to complete full-year Fiscal Year 2027 appropriations before the end of the year, but an agreement remains uncertain. The election results are likely to shape whether congressional leaders seek a year-end deal or another temporary extension into 2027. Disputes over spending levels and the Administration's late-September effort to cancel approximately $810 million in previously approved funding could complicate negotiations.

A health package including extensions of expiring programs and selected bipartisan proposals has been the subject of public speculation and behind-the-scenes discussions, but its scope and timing also remain unresolved. Furthermore, if Congress can only reach an agreement to fund the government through early 2027, the prospect for a larger health care package with long-term program extensions for community health centers and other programs becomes less likely as any health funding extension provisions are likely to track with the length of the government funding bill.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
October 23, 2026

General Update

Governor Newsom had until September 30 to sign or veto bills passed during the final weeks of the 2025–26 Legislative Session. Of the 1,160 bills sent to his desk in 2026, the Governor signed 1,040 and vetoed 120, representing a veto rate of approximately 10.3%. The Governor's veto rate of 10.3% was considerably lower than the 13.4% veto rate in 2025 and 15.7% in 2024, and below his eight-year average of 13.5%.

For CalOptima Health, there were 96 state bills monitored during the two-year legislative cycle. Of those, 45 were signed into law (19 in 2026 and 26 in 2025), eight were vetoed (six in 2026 and two in 2025), and 43 failed to advance through the Legislature. Among the bills signed was AB 2194 (Valencia), the legislation making changes to CalOptima Health's governance structure, which the Governor signed on September 27.

Sacramento's attention has now turned to the November 3 election and the political landscape that will shape the next legislative session. All 80 Assembly seats and 20 of the 40 Senate seats are on the ballot, along with the gubernatorial race. The new Legislature will be sworn into office on December 7, beginning the organizational process for the next two-year session. The new Governor will take office January 4, bringing potential changes in legislative priorities, agency leadership and the direction of state healthcare policy.

Budget Update

Stronger State Revenues, Continued Budget Deficits. California's revenues continue to exceed expectations, although the state's structural budget deficit remains a concern. State Controller Malia Cohen reported that September General Fund revenues totaled $22.9 billion, exceeding projections by $2.9 billion (14.4%). Budget expert Jason Sisney also reported that income tax collections for the first three months of the fiscal year were $4.2 billion (12.1%) above projections.

However, year-to-date state spending is also running $11.8 billion (13.3%) above Budget Act estimates. While the stronger revenues provide some short-term relief, the Legislative Analyst's Office (LAO) continues to warn that ongoing spending commitments exceed projected revenues, particularly in Medi-Cal and other major state programs. The LAO's annual Fiscal Outlook, expected in November, will provide the first independent estimate of the 2027-28 budget gap.

Increased Federal Scrutiny of Medi-Cal. Federal actions are creating additional financial uncertainty for Medi-Cal. Beyond the impacts of H.R. 1 and the upcoming transition of Unsatisfactory Immigration Status (UIS) members to fee-for-service (FFS), the Trump Administration has increased scrutiny of California's Medi-Cal program over allegations of fraud and improper federal reimbursements. In September, the U.S. Department of Health and Human Services (HHS) Office of Inspector General reported that during federal fiscal year 2023, California's Medicaid Fraud Control Unit identified $231.2 million in overpayments across 26 cases, including $99.3 million in federal funds that the state was required to report to CMS. The audit found

that California failed to report and return approximately $47.8 million of the federal share and reported another $32.1 million late. The Inspector General recommended that DHCS return the unreported funds and strengthen its reporting procedures. The state agreed with three of the four recommendations. These findings could require additional repayments and place further pressure on the state's Medi-Cal finances.

MCO Tax Lawsuit. On October 2, the California Medical Association (CMA) and California Association of Health Plans (CAHP) filed a lawsuit with the California Supreme Court challenging changes to the state's Managed Care Organization (MCO) tax enacted in Senate Bill (SB) 125 as part of the 2026–27 State Budget. The organizations argue that the changes violate voter-approved Proposition 35 (2024) by increasing taxes on commercial health plans and establishing a new tax structure without the three-fourths legislative vote required to amend the measure. CalOptima Health submitted an amicus curiae ("friend of the court") letter to the court on October 21, in support of the lawsuit filed by CAHP and CMA.

The Newsom Administration maintains that the changes are necessary to comply with new federal requirements under H.R. 1 and preserve Medi-Cal funding. The Administration's restructured MCO tax under SB 125 is projected to generate approximately $2.3 billion annually from 2027 through 2029, compared with approximately $7.6 billion under the current structure, which will no longer be permitted under federal rules. With the existing federally approved tax expiring on December 31, 2026, and the replacement requiring federal approval, an adverse court ruling could force the state to revise its financing structure, replace lost revenues with General Fund dollars or reduce planned Medi-Cal expenditures.

Looking Ahead. These pressures could create difficult choices in the next 2027–28 State Budget, including reductions or delays in Medi-Cal provider payment increases, tighter managed care funding, additional limits on optional benefits and Community Supports, and further eligibility or administrative changes. For CalOptima Health, the greatest concerns are potential reductions in state funding, additional administrative costs associated with federal requirements and increased pressure on the provider network as the state seeks to control Medi-Cal spending.

Administrative Update

UIS Transition to FFS. DHCS continues preparing for the January 1, 2027, transition of UIS members from Medi-Cal managed care to Medi-Cal FFS. In October, DHCS released additional provider guidance, including a new FFS Provider Toolkit addressing enrollment, billing, treatment authorizations and continuity of care. Statewide, preliminary DHCS data indicates that approximately 43% of providers currently serving UIS members are not actively participating in FFS, while nearly 295,000 members may require additional assistance transitioning their care. DHCS is also expanding member navigation services, including a $7.1 million program administered through the California Primary Care Association (CPCA). For CalOptima Health, the immediate priorities remain ensuring providers are prepared to accept FFS patients and coordinating care for members with complex medical needs before the transition.

H.R. 1 Eligibility Changes. Beginning January 1, 2027, certain low-income adults ages 19–64 who qualify for Medi-Cal under the Affordable Care Act (expansion adults), as well as certain state-funded UIS adult members, will be subject to new work and community engagement requirements unless exempt. Members must generally complete 80 hours per month of qualifying activities, attend school at least half-time or earn approximately $580 per month. Exemptions include pregnancy, disability, serious medical conditions and caring for young children. Beginning March 1, 2027, expansion adults will also be required to renew their Medi-Cal eligibility every six months rather than annually, and their retroactive coverage will be reduced to one month (or two months for all other members). Separately, federal funding for certain qualified noncitizens ended October 1, 2026, with California continuing their full-scope Medi-Cal coverage using state-only funds through June 30, 2027.

PACE Strategic Planning. On October 16, DHCS notified PACE organizations, CalPACE, the National PACE Association and managed care plan associations of a new statewide initiative to develop a PACE Strategic Growth Framework to guide the program's future growth, sustainability and oversight. DHCS is partnering with the California Health Care Foundation, the SCAN Foundation, and external consultants, and will gather stakeholder input through surveys, interviews, focus groups and meetings. The framework is expected to be completed in early 2028. The initiative follows DHCS's pause on new PACE applications and service area expansions, in effect since November 2025 and set to run through at least November 2027, which may be extended given the framework's timeline.

CalAIM and Community Supports. DHCS continues evaluating the financial sustainability of CalAIM, including changes to Community Supports and other services provided through Medi-Cal managed care. An October 20 webinar addressed DHCS's revised recuperative care definition, effective January 1, 2027, and the planned phaseout of short-term post-hospitalization housing. DHCS will also hold a joint meeting of its Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee on October 28, followed by an October 30 webinar on its CalAIM best practices and sustainability toolkits. These discussions could shape future program requirements and funding decisions as the state prepares its 2027–28 budget. For CalOptima Health, the primary concern will be preserving effective care coordination and services for high-need members while managing potential changes to state funding and program requirements.

Medi-Cal Asset Limits for Seniors and People with Disabilities. California reinstated asset limits for certain Medi-Cal recipients, including seniors and people with disabilities, at $130,000 beginning January 1, 2026. Under the 2026–27 State Budget, that limit will drop to $21,000 on July 1, 2027. A primary residence and one vehicle are generally exempt, but savings and certain other assets count toward eligibility. According to an October 22 CalMatters report, approximately 600 individuals statewide have already lost Medi-Cal coverage under the $130,000 limit. Advocates expect significantly more individuals to lose eligibility when the lower limit takes effect, although the state has not released an estimate of the potential coverage losses. For CalOptima Health, the changes could increase eligibility-related disenrollments and disruptions in care, particularly among members receiving long-term services and supports.

Proposition Update

2026 Billionaire Tax Act (Proposition 40). Proposition 40 would impose a one-time 5% tax on the net worth of California billionaires, with 90% of revenues dedicated to healthcare. The campaign has become one of the most expensive in California history, with SEIU-UHW and other supporters contributing more than $32 million, while opponents have raised more than $114 million in direct opposition, according to campaign finance data updated October 16. Billionaire-backed groups are also funding competing Propositions 41 and 42. Governor Newsom, both gubernatorial candidates and several major healthcare organizations oppose the measure, while the California Democratic Party and SEIU-UHW support it. An October 9–14 UC Berkeley Citrin Center/Politico poll found 46% support and 43% opposition among likely voters, compared with 45% support and 42% opposition in a September Berkeley IGS poll.

Clinic Funding Accountability and Transparency Act (Proposition 44). Proposition 44 would require nonprofit Federally Qualified Health Centers (FQHCs) to spend at least 90% of revenues on patient care and other program services, as defined by the Attorney General. SEIU-UHW supports the measure, while CPCA, CMA, other healthcare organizations and both the California Democratic and Republican parties oppose it, warning that it could financially destabilize community clinics.

The campaign is also the subject of a federal racketeering lawsuit filed September 18 by CPCA and five community health centers against SEIU-UHW and its president, Dave Regan. The lawsuit alleges the union used Proposition 44 to pressure clinics into accepting union-organizing agreements, allegations the union denies. The case remains pending; the court has set an initial joint status report deadline of January 5, 2027. A September PPIC poll found 34% support and 61% opposition among likely voters. As of October 16, according to CalMatters' campaign finance tracker, opponents have raised approximately $38.4 million, compared with $16.9 million for the SEIU-UHW-backed support campaign.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 483 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**07/16/2025** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **06/04/2025** Passed Senate floor	CalOptima Health: Watch
SB 490 Umberg	**Alcohol and Drug Programs:** Would have implemented specific timelines for the California Department of Health Care Services (DHCS) to investigate unlicensed treatment facilities (i.e., sober living homes) that were unlawfully advertising or providing services. ***Potential CalOptima Health Impact*:** Increased oversight of treatment facilities that serve CalOptima Health members.	**09/30/2026** Vetoed	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Requires 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.	**09/30/2026** Signed into law	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders (SUDs) at a qualified youth drop-in center, defined as a center providing behavioral or primary health and wellness services to youth 12 to 25 years of age with the capacity to provide services before and after school hours and that has been designated by or embedded with a local educational agency or institution of higher education. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**07/16/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Concerns
SB 874 Weber-Pierson	**Behavioral Health Treatment (BHT) Workgroup:** Requires any provider of BHT services under Medi-Cal to complete criminal background checks. Additionally, requires DHCS to use existing stakeholder forums to review the implementation of BHT services in Medi-Cal and release clinical guidance and treatment plan requirements. ***Potential CalOptima Health Impact:*** Enhanced oversight and quality of BHT services provided to members under 21 years of age with autism spectrum disorder and/or related conditions.	**09/27/2026** Signed into law	CalOptima Health: Watch
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**01/16/2026** Died in Assembly Business and Professions Committee **03/13/2025** Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch
AB 348 Krell	**Full-Service Partnership:** Establishes presumptive eligibility for Full-Service Partnership programs contingent upon meeting criteria and receiving recommendation for enrollment by a licensed behavioral health clinician. ***Potential CalOptima Health Impact*:** Increased continuity of care for members with serious mental illness.	**10/13/2025** Signed into law	CalOptima Health: Watch

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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 951 Ta	**Autism Diagnosis:** Prohibits a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**07/30/2025** Signed into law	CalOptima Health: Watch
AB 1970 Harabedian	**Mental Health and SUD Utilization Management:** Would prohibit a health plan from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of a mental illness or SUD. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**06/24/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/18/2026** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 1 Arrington (TX)	**One Big Beautiful Bill Act:** Makes substantial changes to Medicaid program funding and policies, including but not limited to the following: • Work, community service and/or education requirement of 80 hours per month for able-bodied adults without dependents (with exceptions for pregnant women, foster youth, medically frail, caregivers and others), effective December 31, 2026, or no later than December 31, 2028 • Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026 • Emergency Medicaid services provided to all undocumented beneficiaries subject to the traditional Federal Medical Assistance Percentage (FMAP) — 50% in California — regardless of the FMAP for which those would otherwise be eligible, effective October 1, 2026 • Cost-sharing for MCE enrollees with incomes of 100–138% Federal Poverty Level (FPL), not to exceed $35 per service and 5% of total income, and not to be applied to primary, prenatal, pediatric, or emergency care, effective October 1, 2028 • Prohibition on any new or increased provider taxes, effective immediately • Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively repeal California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to three fiscal years (FYs) ***Potential CalOptima Health Impact*:** Reduced funding to CalOptima Health and contracted providers; decreased number of members; increased administrative costs; implementation of co-pay systems; increased financial and administrative burdens for some existing members; decreased health care utilization by some existing members; reduced benefits for some existing members. A separate overview is also enclosed.	**07/04/2025** Signed into law	**05/20/2025** CalOptima Health: OPPOSE

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 7148 Cole (OK)	**Consolidated Appropriations Act, 2026:** Provides FY 2026 appropriations for several federal departments and agencies, including the U.S. Department of Health and Human Services (HHS), as well as extends several expiring health care programs and increase health care oversight. Specifically, the bill strengthens compliance among pharmacy benefit managers (PBMs), extends Medicare telehealth flexibilities through December 31, 2027, extends the hospital-at-home waiver for five years, and delays Medicaid disproportionate share hospital (DSH) cuts until FY 2028. ***Potential CalOptima Health Impact:*** Continued access to Medicare telehealth flexibilities for dual-eligible CalOptima Health members and delayed cuts to certain contracted hospitals.	**02/03/2026** Signed into law	CalOptima Health: Watch
SB 101 Wiener **AB 102** Gabriel	**Budget Act of 2025:** Makes appropriations for the government of the State of California for FY 2025–26. Total spending is $321 billion, of which $228.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch
SB 106 Laird	**Budget Act of 2025 Junior:** Amends the Budget Act of 2025 (SB 101/AB 102) by appropriating $90 million to Planned Parenthood in response to H.R. 1 cuts. ***Potential CalOptima Health Impact:*** Continued funding for certain family planning services.	**02/11/2026** Signed into law	CalOptima Health: Watch
SB 111 Laird **AB 109** Gabriel	**Budget Act of 2026:** Makes appropriations for the government of the State of California for FY 2026–27. Total spending is $351.7 billion, of which $251.1 billion is from the General Fund. ***Potential CalOptima Health Impact:*** An overview of the FY 2026–27 Enacted State Budget is enclosed.	**06/29/2026** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 125 Committee on Budget and Fiscal Review	**Medi-Cal MCO Provider Tax Trailer Bill (2026):** Authorizes DHCS to submit a new MCO tax model, effective January 1, 2027, through December 31, 2029, to the U.S. Centers for Medicare & Medicaid Services (CMS). If approved by CMS, a tax amount of $8.85 per member per month would be levied on Medi-Cal and commercial health plan lives (with the Medi-Cal portion to be ultimately reimbursed). ***Potential CalOptima Health Impact:*** An overview of the FY 2026–27 Enacted State Budget is enclosed.	**06/29/2026** Signed into law	CalOptima Health: Watch
SB 164 Committee on Budget and Fiscal Review	**Health Omnibus Trailer Bill I (2026):** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related expenditures in the FY 2026–27 state budget. ***Potential CalOptima Health Impact:*** An overview of the FY 2026–27 Enacted State Budget is enclosed.	**06/29/2026** Signed into law	CalOptima Health: Watch
AB 100 Gabriel	**Budget Acts of 2023 and 2024:** Increases Medi-Cal's current FY 2024–25 General Fund appropriation by $2.8 billion and federal funds appropriation by $8.25 billion in order to solve a deficiency in the Medi-Cal budget. ***Potential CalOptima Health Impact:*** Continued funding for current Medi-Cal rates and initiatives through June 30, 2025.	**04/14/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 113 Gabriel	**Budget Act of 2026 Junior:** Amends the Budget Act of 2026 (SB 111/AB 109) as follows, as it relates to the Medi-Cal program: • Clarifies that the $31 million previously allocated to DHCS for care coordination services to support the transition of Unsatisfactory Immigration Status (UIS) beneficiaries from Medi-Cal MCPs to the Medi-Cal fee-for-service (FFS) system is to be used for enhancements to Medi-Cal Connect and the nurse advice line. • Allocates $9 million to support gender-affirming care services for children and youth. As these dollars are going through the California Department of Health Care Access and Information (HCAI) rather than DHCS, this will be grant-based funding. ***Potential CalOptima Health Impact:*** Additional care coordination for UIS members; expanded access to gender-affirming care services for child and youth members.	**09/18/2026** Signed into law	CalOptima Health: Watch
AB 116 Committee on Budget	**Health Omnibus Trailer Bill I (2025):** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related expenditures in the FY 2025–26 state budget. Provisions related to the Medi-Cal program include but are not limited to the following: • Enrollment freeze for undocumented individuals 19 years or older, effective no sooner than January 1, 2026, with exceptions for pregnant individuals • Implementation of $30 monthly premiums for undocumented individuals ages 19-59, effective no sooner than July 1, 2027 • Reinstatement of the asset limit at $130,000 for individuals, adding $65,000 for each additional household member, capping at 10 members, effective January 1, 2026 • Enacts Program of All-Inclusive Care for the Elderly (PACE) provider sanctions, effective immediately ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 144 Committee on Budget	**Health Omnibus Trailer Bill II (2025):** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related expenditures in the FY 2025–26 state budget. Specifically, this bill: • Establishes the list of immunizations by the Advisory Committee on Immunization Practices (ACIP) • Exempts foster youth and former foster youth with UIS from various service limitations in the Medi-Cal program (including enrollment freeze and monthly premiums) • Requires DHCS to convene a workgroup to discuss the implementation of the Children and Youth Behavioral Health Initiative (CYBHI) school fee schedule • Establishes the Abortion Access Fund to provide family planning services through grants and contracts • Requires Covered California to provide payments to qualified health plans to defray the costs of state-mandated gender-affirming care benefits ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**09/17/2025** Signed into law	CalOptima Health: Watch

AB 173 Committee on Budget	**Health Omnibus Trailer Bill II (2026):** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related expenditures in the FY 2026–27 state budget. Provisions related to the Medi-Cal program include but are not limited to the following: • Exempts pregnant and postpartum individuals from the upcoming elimination of Medi-Cal dental coverage for UIS individuals ages 19 years or older, effective July 1, 2027. • Beginning October 1, 2026, requires medically necessary dialysis, including related transportation services, to be covered for individuals with restricted-scope Medi-Cal, even when the treatment does not meet the definition of an emergency medical condition. • Beginning October 1, 2026, Qualified Non-Citizens (QNC) no longer eligible for federal match funding due to H.R. 1 can continue to receive full-scope Medi-Cal through June 30, 2027, but they will be included in the UIS transition from Medi-Cal MCPs to Medi-Cal FFS on January 1, 2027. Subsequently, on July 1, 2027, QNC individuals will only be eligible for restricted-scope Medi-Cal. • Requires DHCS and the California Department of Aging to examine Community-Based Adult Services (CBAS) center closures and their impact and deliver a report to the Legislature by March 1, 2029. • Expands DHCS authority to take the following actions to improve Medi-Cal provider oversight and program integrity: o Deny or terminate Medi-Cal provider enrollment when a provider has certain affiliations with entities that have experienced a disclosable event and DHCS determines there is an undue risk of fraud, waste and abuse (FWA). o Temporarily suspend providers under investigation for FWA and make suspensions effective more quickly. o Impose provider enrollment moratoria, including removing existing exemptions for certain clinics and health professionals.	**09/18/2026** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
	• Directs the state to develop recommendations for sustainable funding of mobile crisis teams and behavioral health crisis services, including maximizing Medi-Cal rates and federal funding. • Appropriates $112.8 million in federal funds to DHCS for State Opioid Response Grant and Substance Abuse Prevention and Treatment Block Grant activities through June 30, 2027. ***Potential CalOptima Health Impact:*** Increased access to certain services for some UIS and QNC members transitioning to Medi-Cal FFS; increased oversight of contracted providers.		
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers that demonstrate capability of providing access and meeting quality requirements when covering the ECM benefit and/or Community Supports. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. ***Potential CalOptima Health Impact*:** Increased collaboration with community providers and standardized contracts.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/27/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Watch LHPC: Oppose
AB 543 Gonzalez	**Street Medicine:** Authorizes a Medi-Cal MCP to elect to offer Medi-Cal covered services through a street medicine provider. MCPs that elect to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment. Additionally, requires the MCP to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary for covered services within the appropriate network and share that information with the relevant county for inclusion in CalSAWS. ***Potential CalOptima Health Impact*:** Continued access to street medicine services for members experiencing homelessness.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2138 Krell	**ECM Peer Support Specialists:** Would require ECM providers to include at least one peer support specialist in their interdisciplinary teams; specialists would have lived experience with recovery from mental illness and/or substance use. Additionally, would outline conditions where peer support specialists cannot be disqualified based on criminal background, fingerprint-based background check or similar screening that is a condition of employment, contracting, certification, credentialing, enrollment or participation in providing peer support services. ***Potential CalOptima Health Impact*:** Expanded access to peer support specialists for certain high-need members.	**04/23/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 2348 Bonta	**ECM and Community Supports Extension:** Extends ECM and Community Supports within the Medi-Cal managed care program beyond the existing CalAIM initiative, beginning January 1, 2027. Additionally, implements quarterly public reporting on Community Supports utilization with ongoing technical assistance to MCPs. ***Potential CalOptima Health Impact*:** Safeguards access to Community Supports for Medi-Cal members.	**09/27/2026** Signed into law	CalOptima Health: Watch
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Prohibits a health plan, effective January 1, 2026 (or a policy offered in the individual or small group market, effective January 1, 2027), from imposing a copayment or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Additionally, requires a health plan to cover all types of insulin without step therapy on and after January 1, 2026. ***Potential CalOptima Health Impact:*** Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** Expresses the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Additionally, upon approval from HHSs and by January 1, 2027, requires the new benchmark plan include certain additional benefits, including coverage for fertility services, hearing aids and exams, and durable medical equipment. ***Potential CalOptima Health Impact:*** New covered benefits for future members enrolled in Covered California line of business.	**10/13/2025** SB 62 signed into law **10/13/2025** AB 224 signed into law	CalOptima Health: Watch CAHP: Concerns
SB 535 Richardson **AB 575** Arambula	**Obesity Care Access Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one specified anti-obesity medication and bariatric surgery for the treatment of obesity. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**07/15/2025** SB 535 passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** SB 535 passed Senate floor **02/24/2025** AB 575 referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
SB 912 Cervantes	**Comprehensive Perinatal Services:** Would require DHCS to oversee a statewide community-based perinatal services program and enroll providers to deliver such services, but would maintain the role of the California Department of Public Health (CDPH) in regard to contracts, grants and agreements. ***Potential CalOptima Health Impact:*** Enhanced access to and delivery of perinatal services for pregnant and postpartum members.	**04/22/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
SB 944 Wiener	**Acupuncture Coverage:** Would have subjected Medi-Cal coverage of acupuncture to utilization controls and the availability of federal financial participation. If federal financial participation was not available, coverage would have been subjected to appropriation by the Legislature. ***Potential CalOptima Health Impact:*** Maintained covered benefits for members.	**09/30/2026** Vetoed	CalOptima Health: Watch
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch

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.	**01/23/2026** Died in Assembly Appropriations Committee **01/13/2026** Passed Assembly Health Committee **02/10/2025** Referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 350 Bonta	**Fluoride Treatments:** Would require a health plan to provide coverage for fluoride varnish in the primary care setting for children under 21 years of age by January 1, 2026. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**08/29/2025** Passed Senate Appropriations Committee; referred to Senate floor **07/02/2025** Passed Senate Health Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 432 Bauer-Kahan	**Menopause:** Would have required a health plan that covers outpatient prescription drugs to provide coverage for evaluation and treatment options for symptoms of perimenopause and menopause. Would also have required a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. ***Potential CalOptima Health Impact:*** New covered benefits for members; increased communications to providers.	**10/13/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1949 Lee	**Acupuncture Treatment Flexibility:** Subject to federal financial participation, would have required Medi-Cal coverage of up to 24 acupuncture visits per beneficiary per calendar year. Additional visits per year could have been authorized based on medical necessity. ***Potential CalOptima Health Impact:*** Expanded covered benefit for members.	**09/30/2026** Vetoed	CalOptima Health: Watch
AB 2160 Celeste Rodriguez	**Lactation Services:** Requires DHCS to update Medi-Cal's coverage guidance on lactation services by July 1, 2027, to clarify coverage policies for various lactation services, including health education, support and consultation. ***Potential CalOptima Health Impact:*** Expanded access to lactation services for members.	**09/27/2026** Signed into law	CalOptima Health: Watch
AB 2208 Stefani	**Federally Mandated Copayments:** In accordance with the minimum requirements of H.R.1, would set copayments at $0.01 for nonemergency services delivered to Medicaid Expansion adults with incomes between 100% and 138% of the federal poverty level, no later than October 1, 2028. Would exempt emergency and family planning services from copayments and prohibit service denial due to unpaid copayments. In addition, would allow self-attestation for Medi-Cal eligibility, including related to work or community engagement activities. ***Potential CalOptima Health Impact:*** Minimized financial burden on Medi-Cal members; decreased member burden to enroll in or maintain Medi-Cal coverage; minimized loss of members due to H.R. 1.	**07/01/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2026** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2240 Stefani	**Private Duty Nursing for Specialty Care:** Would require DHCS to measure and assess whether private duty nursing services provided as part of the EPSDT benefit are in compliance with federal Medicaid requirements. The assessment would include a comparison of the hours of authorized EPSDT private duty nursing services to the hours actually provided to eligible children, as well as a determination of whether reimbursement rates are sufficient to ensure that all authorized hours are able to be provided. ***Potential CalOptima Health Impact:*** Expanded access to care for youth Medi-Cal members; increased reimbursement rates to private duty nurses.	**04/22/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
SB 1202 Weber Pierson	**Eligibility Dashboard and Outreach:** Would mandate the development of a data dashboard to track Medi-Cal application and enrollment data, reflecting changes in federal Medicaid law. Would also require DHCS and Medi-Cal MCPs to conduct outreach and education to Medi-Cal beneficiaries about community engagement requirements and changes to eligibility while aligning cultural and linguistic standards. In addition, would remove the requirement for Medi-Cal MCPs to contact a beneficiary for permission to share contact information with the county for eligibility determination purposes. ***Potential CalOptima Health Impact:*** Improved visibility of member eligibility and enrollment data; increased outreach to and engagement with members; modified data sharing process with the Orange County Social Services Agency; increased retention of existing Medi-Cal members.	**06/09/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/19/2026** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1422 Durazo	**Medi-Cal Eligibility:** Would repeal the Medi-Cal enrollment freeze for UIS individuals who are 19 years of age or older, which was included in the FY 2025–26 Enacted State Budget and became effective on January 1, 2026. Additionally, would require the California Department of Finance to determine and report to the Legislature and the Governor the cost of re-implementing full-scope Medi-Cal benefits for UIS individuals and whether including those costs in the General Fund would create a deficit; following such determination, implementation would be staggered by age, beginning with those over 49 years of age. Certain limitations would be maintained, such as the elimination of dental benefits and the implementation of $30 monthly premium payments. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal eligibility for UIS individuals; increased number of members.	**05/14/2026** Passed Senate Appropriations Committee; referred to Senate floor **04/09/2026** Passed Senate Health Committee	CalOptima Health: Watch
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** Would exempt any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal FFS delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. ***Potential CalOptima Health Impact:*** Decreased number of members.	**01/23/2026** Died in Assembly Appropriation Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**01/31/2026** Died at Assembly desk **02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to all beneficiaries within a geographic region who have been affected by a state of emergency or a health emergency. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**01/23/2026** Died in Assembly Appropriations Committee **04/29/2025** Passed Assembly Health Committee **04/08/2025** Passed Assembly Human Services Committee	CalOptima Health: Watch
AB 1907 Addis	**Aligned Covered California Enrollment:** Authorizes Covered California to enroll an individual in the plan in which other members of the individual's household are enrolled, or the lowest cost plan available. ***Potential CalOptima Health Impact:*** Increased enrollment in future Covered California line of business; streamlined enrollment process for certain members.	**09/15/2026** Signed into law	CalOptima Health: Watch
AB 2161 Bonta	**Community Engagement Implementation:** Integrates federal community engagement requirements into the Medi-Cal program. Prevents California from extending H.R. 1's work requirements to state-funded Medi-Cal populations. Also minimizes administrative load by automating verification using available data sources and requires that any federal work requirement implementation be applied in the least burdensome way possible. ***Potential CalOptima Health Impact*:** Modifications to eligibility for certain members; minimized impact of new community engagement requirements.	**09/15/2026** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2201 Boerner	**Eligibility Redetermination Changes:** Subject to an appropriation, would seek to align state provisions for Medi-Cal eligibility redeterminations with federal requirements, such as changing the current 12-month renewal cycle to a six-month cycle for adults covered under Medicaid Expansion. Additionally, would encourage counties to verify beneficiary income and assets through existing data sources to streamline the redetermination process. ***Potential CalOptima Health Impact*:** Modifications to eligibility redetermination for certain members.	**07/01/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2363 Bains	**Coverage Penalty Exemption:** Would prohibit the imposition of a penalty for not maintaining minimum essential health coverage on individuals enrolled in Medi-Cal in 2024 or 2025. ***Potential CalOptima Health Impact:*** Reduced financial penalties for certain current and future members.	**02/19/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Authorizes disclosures of HIV test results that identify or include identifying characteristics of a Medi-Cal beneficiary without written authorization of the member or their representative to the MCP for quality improvement efforts such as value-based payment and incentive programs. ***Potential CalOptima Health Impact:*** Increased quality oversight of HIV program development.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Prohibits a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Also prohibits these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Extends current Medi-Cal time and distance standards until January 1, 2029. In addition, requires a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS, unless already required to do so. Additionally, the use of telehealth providers to meet time or distance standards does not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. ***Potential CalOptima Health Impact:*** Increased oversight of contracted providers; increased reporting to DHCS.	**10/06/2025** Signed into law	CalOptima Health: Watch
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Requires the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, expands DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**10/03/2025** Signed into law	CalOptima Health: Watch
SB 987 Weber Pierson	**California Health Access Fund (CHAF):** Would require DHCS to administer the CHAF to ensure California residents who lose health care coverage due to the impacts of H.R. 1 (or other divestments from health care services) can continue to receive health care services and that providers are also reimbursed for these services. Furthermore, money in the fund would include deposits equal to the amount of any savings to the state that resulted from decreased enrollment in the Medi-Cal program caused by enrollment barriers from new federal policy changes. ***Potential CalOptima Health Impact:*** Extended health care benefits for certain future former members.	**03/26/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 45 Bauer-Kahan	**Reproductive Data Privacy:** Prohibits the collection, use, disclosure, sale, sharing, or retention of the information of a person who is physically located at, or within a precise geolocation of, a family planning center, except any collection or use necessary to perform services or provide goods that have been requested. Also authorizes an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. ***Potential CalOptima Health Impact:*** Increased safeguards regarding reproductive health information.	**09/26/2025** Signed into law	CalOptima Health: Watch
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project or grant program for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Additionally, would require a health care provider, physician's office, clinic or infusion center to obtain consent from an enrollee and disclose a good faith estimate of the applicable cost-sharing amount before supplying or administering an injected or infused medication. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**01/23/2026** Died in Assembly Appropriations Committee **04/29/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, requires DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**10/07/2025** Signed into law	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**01/16/2026** Died in Assembly Health Committee **04/22/2025** Re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2194 Valencia	**CalOptima Health Governance:** Implements staggered terms on the CalOptima Health Board of Directors (Board) for the seven seats with four-year terms (i.e., all regular seats except those held by the two Orange County supervisors and the non-voting Director of the Orange County Health Care Agency [HCA]), in order to improve the continuity of CalOptima Health's governance. Effective for the next terms expected to begin in August 2028, in order to accommodate a transition, the following three Board seats will serve initial two-year terms that would not count against the two-consecutive-term limit: 1. Community clinic representative 2. Practicing licensed medical provider who is not affiliated with a health network 3. Accounting or public finance professional or actively licensed attorney In addition, requires an independent external audit of CalOptima Health's governance procedures and practices, including but not limited to policies related to conflict-of-interest, vendor contracting and procurement, and governance structures and responsibilities, as well as the HCA's nomination process for Board members. ***Potential CalOptima Health Impact:*** Increased continuity of Board representation; increased staff workload to initiate and respond to independent external audit	**09/27/2026** Signed into law	**08/06/2026** CalOptima Health: NEUTRAL
AB 2565 Wallis	**Pharmacist Services:** Would have required DHCS to update its model evidence of coverage (EOC) to explicitly include the obligation of MCPs to cover pharmacist services. ***Potential CalOptima Health Impact:*** Updated member-facing materials, such as EOCs and member handbooks.	**09/27/2026** Vetoed	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.	**01/23/2026** Died in Senate Appropriations Committee **04/30/2025** Passed Senate Health Committee	CalOptima Health: Watch CAHP: Oppose
SB 412 Limón	**Home Care Aides:** Requires a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**10/06/2025** Signed into law	CalOptima Health: Watch
Providers			
SB 32 Weber Pierson	**Timely Access to Care:** Would require DHCS, DMHC and the California Department of Insurance to consult stakeholders for the development and adoption of geographic accessibility standards of perinatal units to ensure timely access for enrollees by July 1, 2027. ***Potential CalOptima Health Impact:*** Additional timely access standards; increased contracting with perinatal units.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch LHPC: Oppose
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — SNFs:** Requires an annually updated provider directory issued by a Medi-Cal MCP to include SNFs as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**10/03/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 306 Becker	**Prior Authorization Exemption:** No later than January 1, 2028, requires health plans — except Medi-Cal MCPs — to eliminate prior authorization for the most frequently approved health care services, except in cases of fraudulent provider activity or clinically inappropriate care. ***Potential CalOptima Health Impact:*** In future Covered California line of business, implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
SB 504 Laird	**HIV Reporting:** Authorizes a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or CDPH to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 1049 Pierson	**Claim Reimbursements:** Grants a provider no less than 90 calendar days to submit a corrected claim after a health care plan denies a claim or sends a notice of overpayment for a claim based on a defect that could be rectified by submitting a corrected claim. Additionally, prohibits denial of a corrected claim on the grounds that the claim was not submitted within another applicable filing deadline. ***Potential CalOptima Health Impact:*** Modified claims review process.	**09/30/2026** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 50 Bonta	**Over-the-Counter Contraceptives:** Allows pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements are limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**09/26/2025** Signed into law	CalOptima Health: Watch
AB 55 Bonta	**Alternative Birth Centers Licensing:** Removes the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**10/11/2025** Signed into law	CalOptima Health: Watch LHPC: Support
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would have required 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 have prohibited a Medi-Cal MCP from developing or using its own criteria for medical necessity and from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**09/27/2026** Vetoed	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Requires health plans — except Medi-Cal MCPs — to use a designated central utility that follows uniform provider directory standards to collect, manage, and verify the consistency and completeness of their provider directories. If a patient relies on inaccurate directory information, requires the provider to be reimbursed at the agreed-upon or otherwise reasonable amount without the patient incurring charges beyond in-network cost-sharing amounts. Also requires that, within 30 days of receiving a request from a health plan, a provider must confirm that its information is current and accurate or update the required information. ***Potential CalOptima Health Impact:*** In future Covered California line of business, modified processes for managing provider directory; increased coordination with providers.	**09/27/2026** Signed into law	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Expands 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.	**09/27/2026** Signed into law	CalOptima Health: Watch
AB 416 Krell	**Involuntary Commitment:** Authorizes a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and exempts the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 510 Addis	**Utilization Review Peer-to-Peer Review:** Would allow a provider to request review of a decision to delay, deny or modify health services by another physician or peer health care professional matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**01/23/2026** Died in Assembly Appropriations Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 512 Harabedian	**Prior Authorization Timelines:** Would have shortened the timeline for prior or concurrent authorization requests to no more than 24 hours via electronic submission or 48 hours via non-electronic submission for *urgent* requests and three business days via electronic submission or five business days via non-electronic submission for *standard* requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. ***Potential CalOptima Health Impact***: Expedited and modified UM procedures for covered Medi-Cal benefits.	**10/06/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**01/23/2026** Died in Assembly Appropriations Committee **04/08/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would have required an approved prior authorization for a health care service requested by an in-network provider to remain valid for at least one year from the date of approval, or the period requested by the treating provider if less than one year. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**09/20/2026** Vetoed	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 787 Papan	**Provider Directory Disclosures:** Would require a health plan to include in its provider directory a statement advising an enrollee to contact the plan for assistance in finding an in-network provider. Would also require the plan to respond within one business day if contacted for such assistance and to provide a list of in-network providers confirmed to be accepting new patients within two business days for urgent requests and five business days for nonurgent requests. Medi-Cal MCPs would not be required to distribute a printed provider directory. ***Potential CalOptima Health Impact:*** Expanded customer service support and staff training; technical changes to CalOptima Health's provider directory.	**06/18/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/05/2025** Passed Assembly floor	CalOptima Health: Watch
AB 1041 Bennett	**Provider Credentialing:** Requires a health plan — except a Medi-Cal MCP — to credential a provider within 90 days of receipt of a completed application; otherwise, a credential is conditionally approved for 120 days, except as specified. A plan is required to notify the provider whether the application is complete within 10 days of receipt. Additionally, requires a health plan to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for future Covered California line of business.	**10/11/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended
AB 1843 Elhawary	**Communicable Disease:** Prohibits health plans from requiring authorization for direct-acting antiviral drugs needed for hepatitis C treatment. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**09/27/2026** Signed into law	CalOptima Health: Watch
AB 1887 Zbur	**Prescription Drug Coverage for Rare Diseases:** Requires a health care service plan – except a Medi-Cal MCP — to complete prior authorization or other utilization review within 30 days for a drug approved for the treatment of a rare disease and prescribed by a specialist with expertise in such disease, unless a biosimilar, interchangeable biologic or generic version of the drug is available. ***Potential CalOptima Health Impact:*** New UM procedure for future Covered California line of business.	**09/27/2026** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2352 Valencia	**Nonprofit Public Benefit Corporations:** Would allow nonprofit public benefit corporations that offer nonspecialty mental health services to be enrolled as Medi-Cal providers. ***Potential CalOptima Health Impact:*** Increased number of contracted mental health providers; increased access to mental health services for Medi-Cal members.	**08/13/2026** Passed Senate Appropriations Committee; referred to Senate floor **06/24/2026** Passed Senate Health Committee **05/27/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2457 Connolly	**Medi-Cal Provider Credentialing:** Would extend the requirements of AB 1041 (2025) to Medi-Cal MCPs. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for Medi-Cal line of business.	**03/25/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to *equal* the lowest of the following metrics: 1. the amount billed; 2. the charge to the general public; 3. 100% of the lowest maximum allowance established by Medicare; or 4. a reimbursement rate based on an average of the lowest amount that other payers and state Medicaid programs are paying. For any such services related to the diagnosis and treatment of sexually transmitted infections on or after July 1, 2027, the Medi-Cal reimbursement rates shall not consider the rates described in clause (4) listed above. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**04/29/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/23/2025** Passed Senate Health Committee	CalOptima Health: Watch
AB 1672 Solache	**PACE Rates:** Would modify how PACE rates are negotiated by eliminating the requirement for consultation during rate setting and instead mandating direct negotiation of rates. Additionally, would require DHCS to provide written responses to comments and the rationale for rate assumptions before federal submission. ***Potential CalOptima Health Impact:*** Modified rate-setting process for PACE line of business.	**08/13/2026** Passed Senate Appropriations Committee; referred to Senate floor **06/03/2026** Passed Senate Health Committee **04/16/2026** Passed Assembly floor	CalOptima Health: Watch CalPACE: Sponsor

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2036 Patel	**Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Reimbursement:** Would clarify how FQHC and RHC services are reimbursed on a per-visit basis, including how such Prospective Payment System (PPS) rates are set and adjusted based on necessary documentation. ***Potential CalOptima Health Impact:*** Improved access to care for members assigned to contracted FQHCs; improved financial stability of contracted FQHCs.	**02/17/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2327 Lowenthal	**Subcontractor Rates:** Would require Medi-Cal MCPs operating as fully or partially delegated subcontractors to be compensated with actuarially sound rates starting January 1, 2027s. ***Potential CalOptima Health Impact:*** Modifications to rate setting for Medi-Cal subcontractors.	**04/21/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Information in this document is subject to change as bills proceed through the legislative process.

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

Last Updated: October 15, 2026

2026 Federal Legislative Dates

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

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

2026 State Legislative Dates

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

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

About CalOptima Health

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

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, 2025, 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, effective **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 continues 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, 2025, to pass legislation, and Gov. Newsom has until October 12, 2025, to either sign or veto that passed legislation.

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Fiscal Year 2026–27 Enacted State Budget

Impact Analysis

July 15, 2026

Background

On January 9, 2026, Governor Gavin Newsom released the Fiscal Year (FY) 2026–27 Proposed State Budget, reflecting a minor $2.9 billion budget shortfall due to increased state program costs and the loss of significant federal funding, despite state tax revenue coming in higher than expected. While the proposed budget did not include any major new commitments or spending reductions, the Medi-Cal program would still be particularly affected as policy changes from federal H.R. 1 legislation, enacted on July 4, 2025, and the previous FY 2025–26 enacted state budget continue to be implemented.

On May 14, Governor Newsom released the FY 2026–27 Revised State Budget Proposal, known as the May Revision, which reflects updated economic forecasts and revenue projections. After accounting for budget solutions, the May Revision proposed $349.4 billion in total funding ($246.6 billion General Fund [GF]). Revenues are projected to be $16.5 billion higher than estimated in January's proposed budget across the three-year budget window, primarily driven by stronger-than-expected personal income tax collections and a spike in capital gains realizations associated with the artificial intelligence boom.

On June 15, the State Senate and State Assembly both passed a counterproposal — Assembly Bill (AB) 109 — as a placeholder budget to meet the June 15 constitutional deadline while negotiations with the governor on a final budget continued.

On June 26, Gov. Newsom and legislative leaders announced a final budget agreement. After both houses of the State Legislature passed the agreed-upon revisions as Senate Bill (SB) 111 on June 29, Gov. Newsom signed both AB 109 and SB 111 into law that same day. Additionally, the Legislature passed and the governor signed the consolidated Health Trailer Bill (SB 164), which contains policy changes needed to implement health-related budget expenditures. Together, these bills — along with additional trailer bills covering other policy areas — represent the FY 2026–27 Enacted State Budget.

Summary

The FY 2026–27 Enacted State Budget includes $351.7 billion in total spending ($251.1 billion GF) to support a balanced budget for FY 2026–27 and positive year-end balances and reserves over the next two FYs through a combination of revenue and spending solutions. New revenue streams include a sales tax on pre-written software projects, limits on business tax credits and a new Managed Care Organization (MCO) tax, as discussed later. In addition, the final budget agreement mitigates several spending reductions proposed in the May Revision by rejecting or delaying them until the following budget year. Still, significant cutbacks in the Medi-Cal program remain included, in part due to new federal Medicaid requirements under H.R. 1 and ongoing guidance from the U.S. Centers for Medicare & Medicaid Services (CMS). Both the State Senate and the State Assembly aim to revisit any included reductions and consider additional delays, restorations or modifications of those reductions as part of the FY 2027–28 budget process, consistent with the state's fiscal condition at that time.

The following are significant provisions in the FY 2026–27 Enacted State Budget that may impact CalOptima Health and its members, providers and stakeholders:

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Medi-Cal Eligibility & Enrollment

- Transition the Unsatisfactory Immigration Status (UIS) population from Medi-Cal managed care plans to the Medi-Cal fee-for-service system (FFS), effective January 1, 2027.
    - The California Department of Health Care Services (DHCS) claims that this is required in response to a State Medicaid Director Letter issued by CMS in September 2025 that disallows coverage of federally eligible emergency Medicaid services within a risk-based managed care delivery system for the UIS population.
    - Program of All-Inclusive Care for the Elderly (PACE) participants are exempt from the transition and are therefore allowed to maintain enrollment in PACE.
    - $39 million has been appropriated to support the transition, including $31 million for care coordination, such as language access, integrated care planning, member outreach, and provider coordination, as well as $8 million for contracts with clinics and community-based organizations to provide navigation services.
    - In total, approximately 117,000 CalOptima Health members will be transitioned, including 295 vulnerable children enrolled in the Whole Child Model program.
- Delay the transition of the Qualified Non-Citizen (QNC) population to restricted-scope Medi-Cal from October 1, 2026, through July 1, 2027. In the meantime, the QNC population will be transitioned alongside the UIS population to Medi-Cal FFS on January 1, 2027.
    - The QNC population includes asylees, refugees, battered noncitizens (and their parents and children), human trafficking victims, humanitarian parolees, Amerasian immigrants, conditional entrants granted before April 1980, individuals paroled into the United States for one year or more, and individuals granted withholding of deportation or removal.
- Require the next governor's FY 2027–28 May Revision to set a Medi-Cal premium between $30 and $50 per month for UIS adults ages 19–59, effective July 1, 2027. A $30-per-month premium was already set to take effect on the same date, pursuant to the FY 2025–26 enacted state budget.
- Further reduce the asset limit for seniors and disabled adults to $21,000 per individual or $31,000 per couple, effective July 1, 2027. An asset limit of $130,000 per individual was recently implemented on January 1, 2026.
- Augment funding by $197 million GF in FY 2026–27 to support increased county workload as a result of H.R. 1 changes to Medi-Cal eligibility and enrollment.
- Appropriate $1.5 million GF in FY 2026–27 to support staffing to enable DHCS to clear the Medi-Cal Home and Community Based Alternatives (HCBA) Waiver waitlist, when future slots are available, to serve all eligible individuals seeking enrollment in the HCBA Waiver program.

Medi-Cal Benefits

- Renew the California Advancing and Innovating Medi-Cal (CalAIM) initiative from January 1, 2027, through December 31, 2031, with the following new components subject to federal approval:
    - **Employment Supports**: A county opt-in benefit to provide employment support services, including job readiness assessments, individualized employment planning, job placement assistance, and post-employment retention services.
    - **BridgeCare Pilots**: A county opt-in benefit to provide home- and community-based services and caregiver supports to individuals enrolled in Medicare who meet the near-dual eligibility criteria.
- Delay the elimination of UIS adult dental benefits until July 1, 2027.

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- Maintain the community-based mobile crisis services benefit until July 1, 2027, despite the expiration of enhanced federal funding.

Medi-Cal Efficiencies

- Strengthen utilization management controls for applied behavior analysis (ABA)/behavioral health treatment (BHT) and transportation services, including non-medical transportation (NMT) and non-emergency medical transportation (NEMT). More details can be found in this DHCS fact sheet. CalOptima Health currently requires prior authorization for ABA/BHT and NEMT services (with exceptions), but not for NMT services.
- Eliminate the incentive component of the Quality Withhold and Incentive Program, which would effectively result in a rate cut to Medi-Cal managed care plans.
- Refine eligibility criteria, referral pathways, service definitions and utilization management criteria for Enhanced Care Management (ECM) and Community Supports, effective January 1, 2027. More details can be found in this DHCS fact sheet. CalOptima Health has already adopted or has recommended adopting several of these proposed reforms to improve the quality and sustainability of the CalAIM program.

Rates and Financing

- Delay the elimination of Proposition 56 dental supplemental payments until July 1, 2027.
- Delay elimination of Prospective Payment System (PPS) rates to community clinics for UIS beneficiaries until July 1, 2027.
- Submit a new MCO Tax model, effective January 1, 2027, due to the expiration of the existing MCO tax on that same date. The new model would consist of two components:
    - The first component would comply with Proposition 35 (2024) but is expected to be rejected by CMS due to noncompliance with the provider tax uniformity requirements under H.R. 1.
    - The second component would comply with H.R. 1 but would not be tied to Proposition 35. Under this component, an $8.85 per member per month (PMPM) tax would be imposed on both Medi-Cal and non-Medi-Cal plans to sustain the Medi-Cal targeted rate increases (TRI) for primary care, maternal health and non-specialty mental health services that were implemented on January 1, 2024. However, this would effectively sweep remaining MCO Tax revenues into the GF to support existing Medi-Cal costs, rather than additional provider rate increases as intended by Proposition 35.
- Appropriate $90 million GF to the California Department of Health Care Access and Information (HCAI) in FY 2026–27 to provide one-time grants to hospitals in immediate and significant financial distress, and authorize the California Department of Finance to augment up to an additional $50 million.
- Appropriate $250 million GF to DHCS in FY 2026–27 to support designated public hospitals.
- Appropriate $30 million GF in FY 2026–27 to support rate increases for private duty nursing.
- Appropriate $26 million to maintain access to gender affirming care through a provider network stabilization program.
- Appropriate $40 million to support uncompensated care and continued access for reproductive health services.

Miscellaneous

- Initiate process to develop and release a proposed “fair share” tax on large corporations whose employees are enrolled in Medi-Cal by April 1, 2027.

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- Appropriate $800,000 annually ongoing to hire additional DHCS nursing staff to evaluate PACE enrollment applications and make level-of-care determinations more timely.
- Increase ongoing funding from $190 million to $300 million annually to expand the state premium subsidy program for Covered California enrollees up to 200% of the Federal Poverty Level, effective July 1, 2026, to partially offset the expiration of the federal enhanced Advance Premium Tax Credits (eAPTCs) on December 31, 2025.
- Augment funding by $223 million GF in FY 2026–27 to support increased county workload as a result of H.R. 1 changes to CalFresh eligibility and enrollment.
- Redirect the state's share of Medical Loss Ratio (MLR) remittances from the Medi-Cal Physician and Dentists Loan Repayment Program to the GF, which would reduce GF costs by $25 million annually ongoing. For context, Medi-Cal managed care plans that fall below the minimum 85% MLR requirement must remit the difference to DHCS.
- Appropriate additional one-time funding of $100 million to food banks in FY 2026–27 as part of the CalFood program.
- Appropriate one-time funding of $16.5 million for diaper banks.

Rejected Proposals

The following notable proposals in the May Revision were ***not*** included in the final budget:

- Eliminate the adult acupuncture benefit, effective January 1, 2027.
- Implement a rate cap for PACE organizations at the lower bound of the actuarial rate range, effective January 1, 2027. A rate cap at the midpoint of the rate range is already set to take effect on the same date. Since CalOptima Health's PACE rates are currently at the midpoint of the rate range, this new proposal would have resulted in an effective rate cut to CalOptima Health.
- Shift the costs of growth in In-Home Supportive Services (IHSS) to counties, eliminate the IHSS Backup Provider System and align IHSS termination with Medi-Cal termination.

Next Steps

State agencies, including DHCS, will begin implementing the policies included in the enacted budget. In addition, the Legislature may consider additional clean-up budget bills and will continue to advance policy bills through the legislative process. The Legislature has until August 31, 2026, to pass legislation, and Gov. Newsom has until September 30, 2026, to either sign or veto that passed legislation. Policy bills with funding allocated in the enacted budget are more likely to be passed and signed into law.

Government Affairs staff will continue to monitor policies included in the enacted budget, engage in any additional necessary advocacy efforts and provide updates on issues that have a significant impact on CalOptima Health. If you have any questions, please contact GA@caloptima.org.

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Member Grievances and Appeals Report Second Quarter 2026

Board of Directors Meeting

November 5, 2026

Heather Sedillo, Grievance and Appeals Resolution Services (GARS), Director

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.

Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.

- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify, or discontinue a covered service.

Grievances

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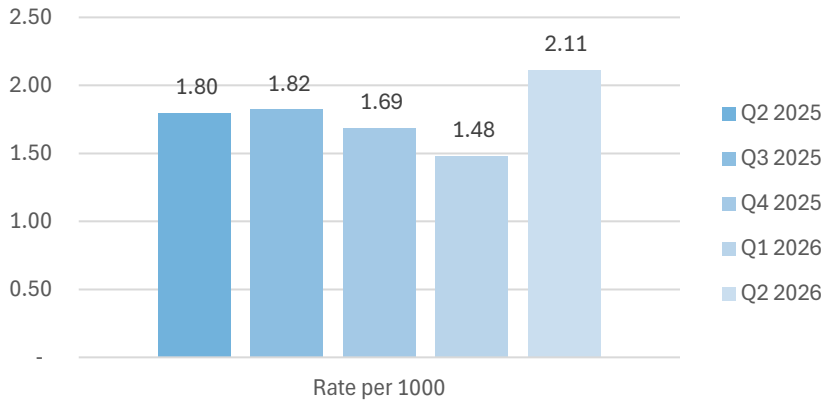
Grievances Q2 2026 Summary

- Total grievance volume (Customer Service (CS) + GARS) increased from 4,925 in Q1 to 6,160 in Q2.
- Grievance category drivers in Q2 shifted to Provider Services/Staff, Transportation, Gift Cards and CalAIM, differing from Q1 drivers.
- CCN remained the highest-volume Health Network (HN), with top grievance drivers being Delay in Referral, Provider Services/ Staff Attitude, and Appointment Availability, differing from Q1 drivers.
- In Q2, from the members with multiple grievances presented in Q1, there was an increase of 71% of grievances submitted in Q2 from that group of members.

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Grievance Volume all LOB's Q2 2025 – Q2 2026

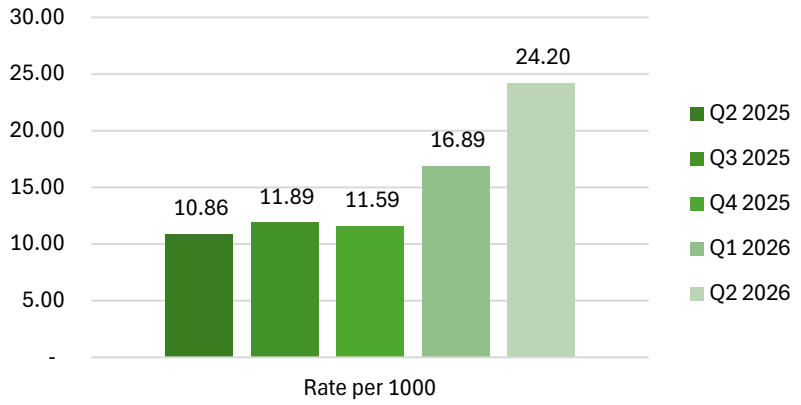
Medi-Cal Grievances Rate per 1,000 Member Months (MM)



Total Grievances

Timeframe	Total Grievances
Q2 2026	4,774
Q1 2026	4,023
Q4 2025	4,554
Q3 2025	4,781
Q2 2025	4,778

OneCare Grievances Rate per 1,000 Member Months (MM)



Total Grievances

Timeframe	Total Grievances
Q2 2026	1,386
Q1 2026	977
Q4 2025	646
Q3 2025	643
Q2 2025	574

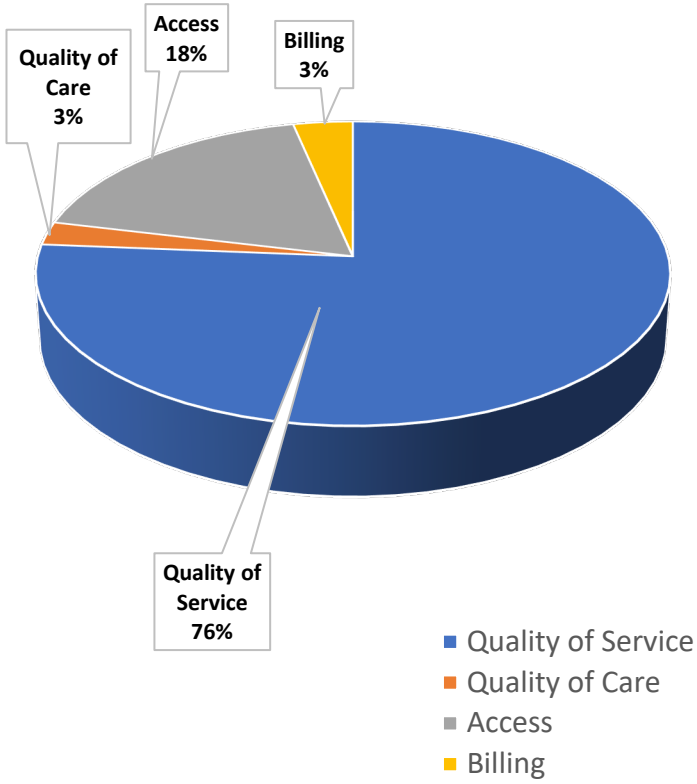
*Data includes CS exempt Grievances

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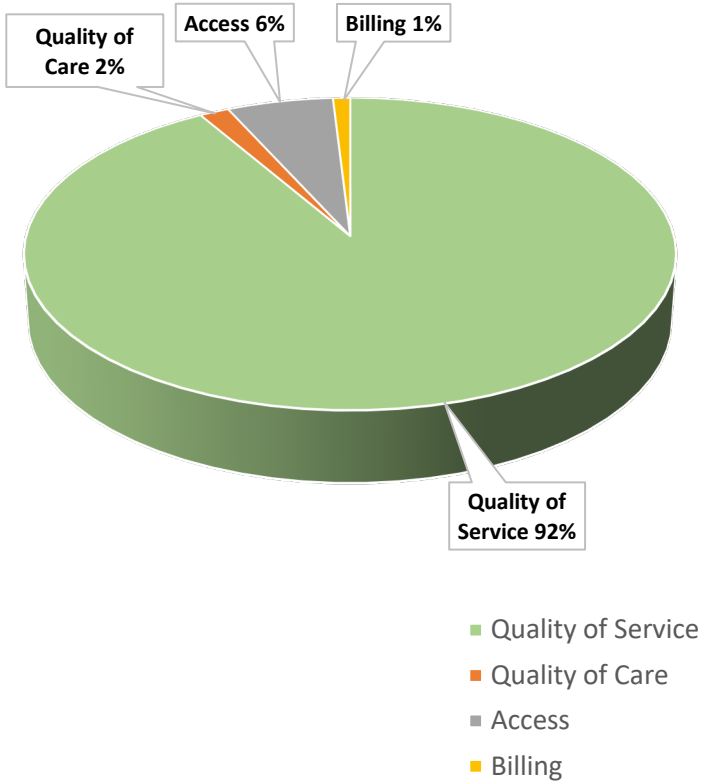
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Medi-Cal and OneCare Q2 2026 Grievance Type by Category

Medi-Cal by Category



OneCare by Category



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Grievance Trends for Q2 2026

Medi-Cal- Quality of Service

Trend	Percentage of Total Volume
Provider Services/Staff	51% (1,442)
Transportation Related	12% (337)
CalAIM related	8% (227)

Medi-Cal- Access

Trend	Percentage of Total Volume
Appointment Availability	21% (137)
Telephone Accessibility	10% (66)
Delay in Referral Provider	10% (66)

OneCare- Quality of Service

Trend	Percentage of Total Volume
Transportation NMT	33% (223)
Provider Services/Staff	20% (136)
Gift Card Related	8% (52)

OneCare- Access

Trend	Percentage of Total Volume
Telephone Accessibility	19% (8)
Delay in Referral by HN	14% (6)
Appointment Availability	12%(5)

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Appeals

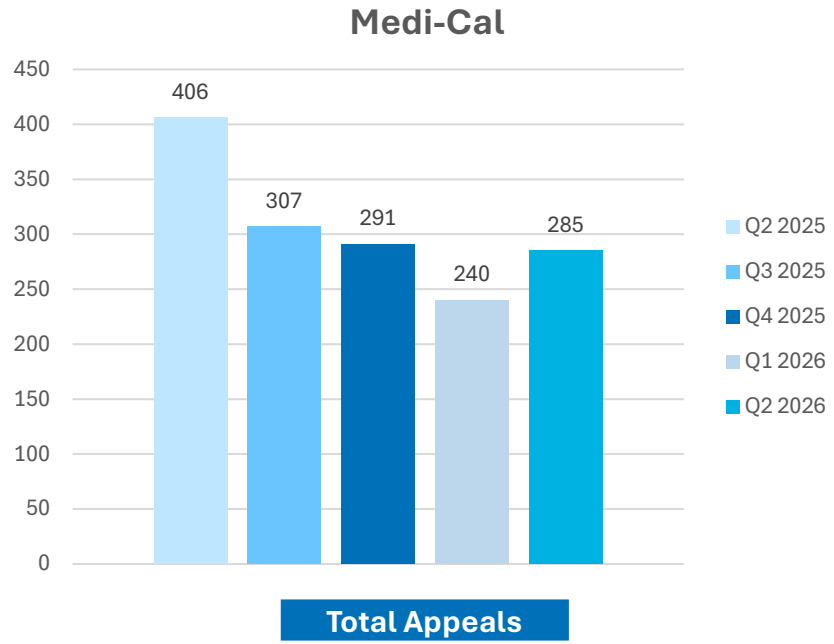
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Appeals Q2 2026 Summary

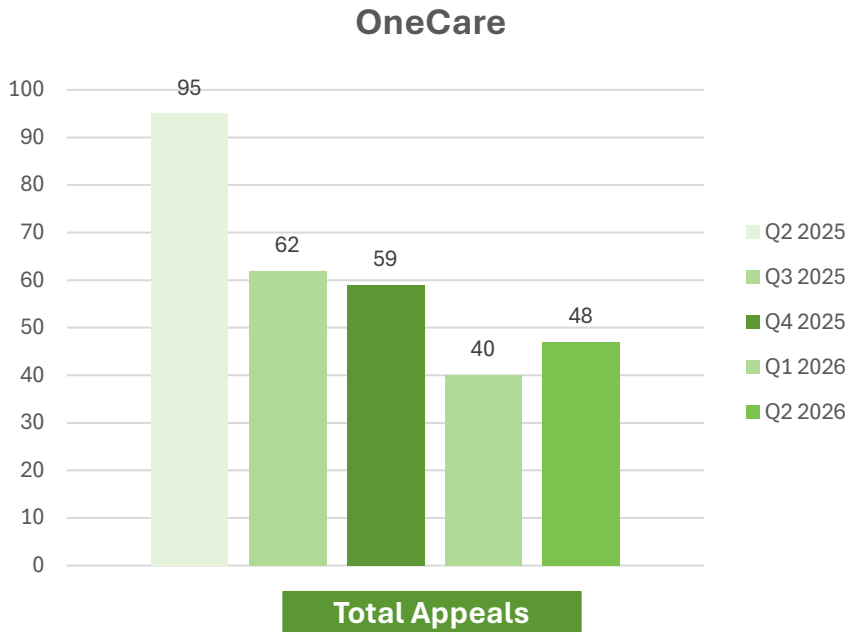
- Medi-Cal and OneCare appeals volume increased by 83 from Q1 to Q2, with 100% compliance and an average turnaround time (TAT) of 24 days for case closures.
- Top overturn reasons: Criteria met based on new information received during the appeal; Community-Based Provider/INN access standards were not met; and the Tertiary Care guideline was met.
- Medi-Cal overturn rates decreased from 36% to 27%. OneCare rates increased from 43% to 49%, respectively.
- UM Provider appeals volume increased from 452 in Q1 to 612 in Q2. The overturn rate continues to decrease. Q2 overturn rate was 4%.
- External reviews (QIO, IRE, SFH) had low overturn rates, except for SNF continued-stay denial appeals (QIO). The leading reason for SNF overturns remains consistent with Q1 – insufficient discharge plan.

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Appeals Volume all LOB Q2 2025 – Q2 2026



Total Appeals	
Q2 2026	285
Q1 2026	240
Q4 2025	291
Q3 2025	307
Q2 2025	406

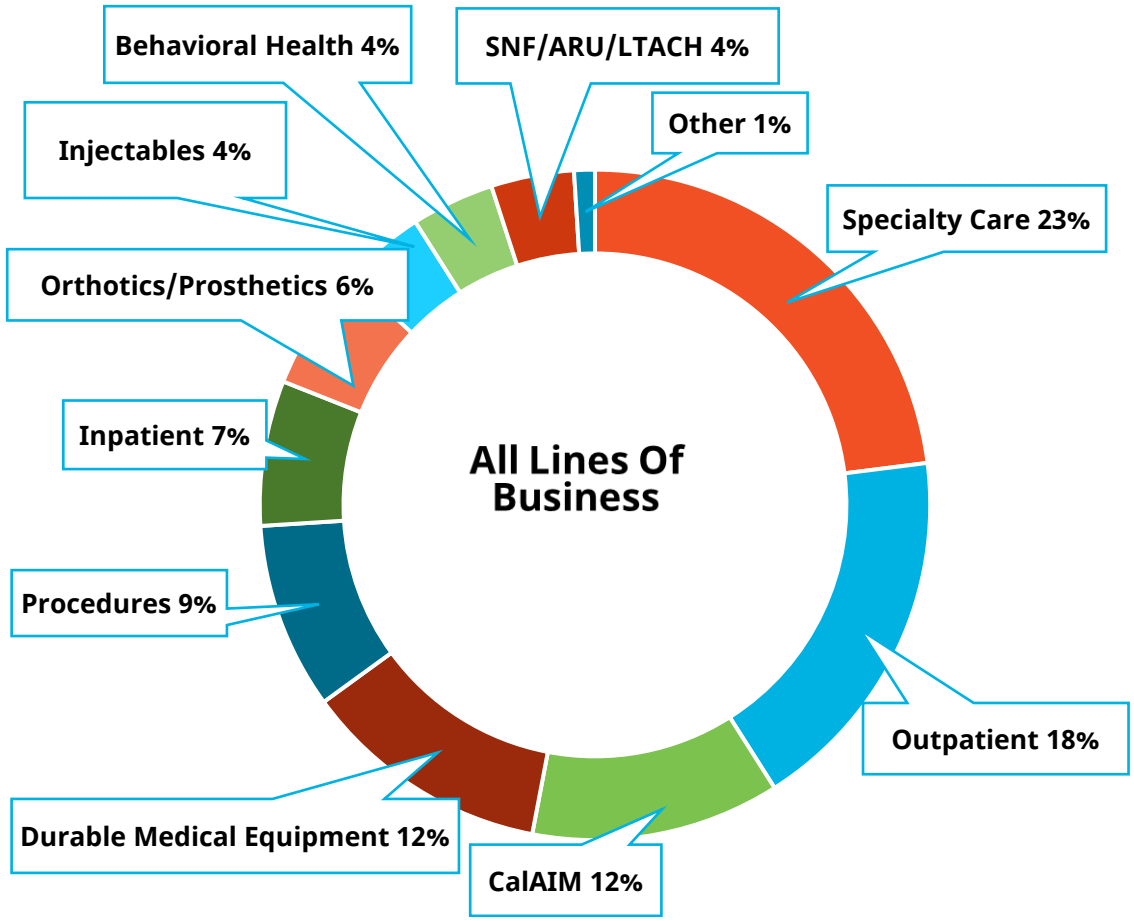


Total Appeals	
Q2 2026	48
Q1 2026	40
Q4 2025	59
Q3 2025	62
Q2 2025	95

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Member Appeals
All Lines of Business
Appealed Services



Services	Qty	%
Specialty Care	84	23%
Outpatient Services	66	18%
CalAIM	45	12%
DME	42	12%
Procedures	32	9%
Inpatient Services	26	7%
Orthotics/ Prosthetics	20	6%
Injectables	16	4%
Behavioral Health (BH)	15	4%
Skilled Nursing/Acute Rehab/Long Term Acute Care	14	4%
Other	3	1%

Keynote: In Q2, DME and Outpatient appeals increased over 50%, while Injectable appeals decreased by 20% compared to Q1.

Q2 2026 Appeals Trends

Medi-Cal Appeals

Type	Overturn Count	Uphold Count	Total	Overturn Percentage (%)
Specialty Care	23	52	75	31%
Outpatient Services	19	29	48	40%
CalAIM related	2	37	39	5%

OneCare Appeals

Type	Overturn Count	Uphold Count	Total	Overturn Percentage (%)
Outpatient Services	9	7	16	56%
DME	4	3	7	57%
CalAIM related	1	5	6	67%

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CalOptima Health Community Outreach Summary — October and November 2026

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and by 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

CalOptima Health will continue its tradition of supporting members and their families during the holiday season by hosting its third annual Thanksgiving Food Distribution and Open House on Saturday, November 21, 2026, from 9 a.m. to 1 p.m. at CalOptima Health. The event brings members together to celebrate the holiday season while providing access to holiday meal items, health programs, and valuable community resources.

Members may choose a turkey, ham, or Northgate gift voucher for vegetarian options, along with traditional side items to help make their Thanksgiving meal special. Distribution is limited to one holiday meal per family, while supplies last.

During the open house, members would have the opportunity to connect with CalOptima Health teams to learn more about Medi-Cal programs and supportive services. Participating departments include Customer Service, Behavioral Health Integration, Culture and Linguistics, PACE, OneCare, Case Management, and CalAIM.

Community partners will also be available to support members and families. The County of Orange Social Services Agency will assist with Medi-Cal and CalFresh enrollment, 211OC will connect members with community resources, and Mercy Health will offer vaccinations.

Through this annual event, CalOptima Health aims to do more than provide holiday food assistance. It creates an opportunity for members to feel supported, engage with staff and community partners and access resources that can make a meaningful difference for them and their families during the holiday season.

We look forward to celebrating the Thanksgiving holiday together again this year.

Summary of Public Activities

As of October 8, CalOptima Health will participate in, organize or convene 89 public activities in October and November. In October, there were 56 public activities, including 14 community/collaborative meetings, 34 community events, six community-based presentations, one Community Connections Meeting, and one Health Network Forum.

In November, there will be 33 public activities, including 13 community/collaborative meetings, 15 community events, four community-based presentations, and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided one endorsement since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for letters of support and use of CalOptima Health's name and logo. For more information on policy requirements, please visit: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of Support for Hurtt Family Health Clinic, Inc., request for continuation funding from the Bureau of Primary Health Care Service Area Competition, Fiscal Year 2027.

For additional information or questions, contact CalOptima Health Executive Director Deanne Thompson at 714-954-2141 or deanne.thompson@caloptima.org.

Attachment to the November 5, 2026, CalOptima Health Outreach Summary

Community Events Hosted by CalOptima Health and Community Partners in October and November 2026:

October 2026

October 1, 8 a.m.–6 p.m., 2026 Orange County Grantmakers Summit, hosted by Orange County Grantmakers

Anaheim Marriott Suites, 12015 Harbor Blvd., Garden Grove

- Sponsorship fee: $2,500; included two complimentary conference tickets, logo on conference webpage and on-screen, text listing (conference eblasts, onsite signage, and program book), and recognition on social media.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 1, 9–10:30 a.m., CalOptima Health Medi-Cal Overview in Spanish and English

Maxwell Elementary School, 2613 W. Orange Ave., Anaheim

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 1, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 3, 8–11 a.m., Walk to End Alzheimer's, hosted by the Alzheimer's Association

Orange Coast College, 2701 Fairview Rd., Costa Mesa

- Sponsorship fee: $2,500; included an exhibitor table at the event.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 3, 9 a.m.–1 p.m., Driving Hope Home, hosted by Homeless Intervention Services of Orange County

Placentia Presbyterian Church, 849 N. Bradford Ave., Placentia

- Sponsorship fee: $2,500; included logo placement on all event materials, resource booth, recognition during event program, social media recognition, HIS-OC website sponsor brand recognition (main page), and newsletter recognition.
- 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

October 3, 10 a.m.–2 p.m., 20 Years Anniversary Celebration and Resource Fair, hosted by the Orange County Family Justice Center

Orange County Family Justice Center, 150 W. Vermont Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 3, 9 a.m.–Noon, Senior Wellness Expo, hosted by the City of Yorba Linda

Yorba Linda Community Center, 4845 Casa Loma Ave., Yorba Linda

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 3, 9 a.m.–3 p.m., OC Free Health Fair, hosted by the Vietnamese Physicians Association of Southern California Foundation

Warner Middle School, 14171 Newland St., Westminster

- Sponsorship fee: $3,000; included resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 3, 9:30 a.m.–Noon, Health Fair, hosted by Hope Community Services

Hope Community Services, 1538 Century Blvd., Santa Ana

- Sponsorship fee: $2,000; included resource booth and speaking opportunity.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 3, 9 a.m.–1 p.m., Free Flu Clinic and Health Fair Event, hosted by the Friends of Family Health Center

Friends of Family Health Center, 501 S. Idaho St., La Habra

- Sponsorship fee: $2,000; included resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 6, 1:30–2:30 p.m., CalOptima Health Medi-Cal Overview in English

Lathrop Intermediate School, 1111 S. Broadway St., Santa Ana

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 6, 5–7:30 p.m., CalOptima Health Medi-Cal Overview in English

Shanti Orange County, 23461 South Pointe Dr., Ste.100, Laguna Hills

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 7, 8 a.m.–5 p.m., 2026 Future of Healthcare Conference, hosted by Advance Orange County

University of California, Irvine, 5270 California Ave., #100, Irvine

- Sponsorship fee: $5,000; included logo featured on all event promotional materials, speaking opportunity, and 10 tickets with reserved seating for one day.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 8, 10 a.m.–1 p.m., CalOptima Health Medi-Cal Overview in English

City of Lake Forest Senior Center, 100 Civic Center Dr., Lake Forest

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

October 8, 11 a.m.–12:30 p.m., Hispanic Heritage Month Celebration, hosted by Huntington Beach Adult School

BESST Center, 2045 Meyer Pl., Costa Mesa.

- Sponsorship fee: $1,500; included marketing, resource table.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 9, 4–7 p.m., Vietnamese Mental Health Conference, hosted by Moving Forward Psychological Institute

CalOptima Health, 505 City Parkway West, Orange

- Sponsorship fee: $5,000; included speaking opportunity at the welcoming and lunch sessions, resource table, acknowledgment on all marketing (website, social media, TV Talk Shows, community outreach and engagement events) materials, large logo on event banner, five VIP conference tickets.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 10, 9 a.m.–Noon, Family Health Fair, hosted by Melinda Hoag Smith Center for Healthy Living, Hospital

Melinda Hoag Smith Center for Healthy Living, 307 Placentia Ave., Ste. 203, Newport Beach

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 10, 9 a.m.–2:30 p.m., InfluenceHER Summit, hosted by Girls Inc. of Orange County

Santa Ana College, 1376 W. 17th St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 10, 10 a.m.–1 p.m., Older Adults Fall Health Fair, hosted by the City of Anaheim

Brookhurst Community Center, 2271 W. Crescent Ave., Anaheim

- Registration fee: $100; included resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 10, Noon–7 p.m., OC Pride 2026 Festival and Parade, hosted by the LGBTQ Center of OC

Downtown Santa Ana, 301 E. 3rd St., Santa Ana

- Registration fee: $505; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 13, 9 a.m.–Noon, Joint Network Meeting, hosted by the Orange County Department of Education

Waugh Student Center, 55 Fair Dr., Costa Mesa

- Sponsorship fee: $2,500; included a resource table, presentation, and marketing.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 13, 9 a.m.–1 p.m., Older Adult Resource Fair, hosted by the Orange County Aging Services

Delhi Center, 505 E. Central Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 14, 11 a.m.–1 p.m., Health and Wellness Fair, hosted by Golden West Student Health Center

Golden West College, 15744 Goldenwest St., Huntington Beach

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 15, 1–5 p.m., ACCESS Title 1 Parent Conference, hosted by the Orange County Department of Education

OCDE ACCESS, 601 S. Lewis St., Orange

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 15, 5–6 p.m., Parenting in the Digital World Resource Fair, hosted by the Garden Grove Unified School District, Department of Parent and Community Outreach

Bolsa Grande High School Gymnasium, 9401 Westminster Blvd., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 17, 10 a.m.–1 p.m., Together on the Spectrum, hosted by the Office of Congressman Lou Correa

Valley High School, 1801 South Greenville St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 17, 10 a.m.–2 p.m., 4th Annual Recovery Happens Picnic, hosted by the Orange County Healthcare Agency

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 19, 9 a.m.–5 p.m., Mobile Mammogram Event, hosted by CalOptima Health

Anaheim Global Medical Center, 1025 S. Anaheim Blvd., Anaheim

- At least four staff members attended
- Health/Resource Fair, open to the public

October 19, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Community Health Enrichment Collaborative and South Orange County Family Resource Center, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

October 20, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 20, 4:30–6 p.m., Valencia Garden Fright Night, hosted by Families Forward

Valencia Garden Apartments, 525 W. Struck Ave., Orange

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 22, 10 a.m.–12:30 p.m., Partner Spotlight and Food Distribution, hosted by Big Brothers Big Sisters of Orange County

Big Brothers Big Sisters Office, 1801 E. Edinger Av., Ste. 101, Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 23, 9 a.m.–1 p.m., Senior Summit, hosted by County of Orange Supervisor Katrina Foley in partnership with CalOptima Health

Aliso Viejo Ranch, 100 Park Ave., Aliso Viejo

- At least five staff members attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

October 24, 10 a.m.–3 p.m., Health and Wellness Fair, hosted by the City of Fullerton
Fullerton Community Center, 340 W. Commonwealth Ave., Fullerton

- Registration fee: $100; included resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 24, 10 a.m.–3 p.m., Octsoberfest, hosted by Action Alliance Foundation
Kiwanis Land Park, 9840 Larson Ave., Garden Grove

- Sponsorship fee: $3,000; included recognition on AAF's website, from the event stage, in the e-newsletter, and on the banner displayed at the event.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 26, 9–11 a.m., CalOptima Health Medi-Cal Overview in Spanish
Anaheim High School, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

October 26, 9 a.m.–5 p.m., Mobile Mammogram Event, hosted by CalOptima Health
South Coast Global Medical Center, 2701 S. Bristol St., Santa Ana

- At least four staff members attended
- Health/Resource Fair, open to the public members

October 27, 9–10:30 a.m., CalOptima Health Community Connections Meeting, hosted by CalOptima Health
CalOptima Health, Virtual

- At least four staff members attended
- Steering committee meeting, open to collaborative members

October 29, 2–6 p.m., Community Health and Resource Fair, hosted by the Office of Assemblymember Tri Ta
Boys & Girls Club of Westminster, 14400 Chestnut St. #5004, Westminster

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

October 29, 4–7 p.m., Dia de Los Muertos, hosted by Buena Clinton Youth and Family Center
Buena Clinton Youth and Family Center, 12661 Sunswept Ave., 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

November 2026

November 2, 4–8 p.m., Dia de Los Muertos, hosted by the University of California, Irvine

Irvine Barclay Theatre, 4242 Campus Dr., Irvine

- Sponsorship fee: $2,000; included resource booth and logo on all banners.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 3, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 4 through 6, 8 a.m.–4 p.m., Head Start California Health Institute, hosted by Head Start California

Hilton Orange County Costa Mesa, 3050 Bristol St., Costa Mesa

- Sponsorship fee: $2,500; included resource booth, registration recognition at event reception, logo on sponsor recognition sign, event website main landing page, company sponsorship webpage recognition in annual report.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

November 4, 8:45–9:45 a.m., CalOptima Health Medi-Cal Overview in Spanish

Mattie Lou Maxwell Elementary School, 2613 W. Orange Ave., Anaheim

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

November 4, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Mattie Lou Maxwell Elementary School, 2613 W. Orange Ave., Anaheim

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

November 5, 9:30–11 a.m., CalOptima Health Medi-Cal Overview in English and Spanish

Ball Junior High School, 1500 W. Ball Rd., Anaheim

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

November 5, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

November 7, 6 a.m.–6 p.m., Disney Days: Reuniting Siblings Separated by Foster Care, hosted by Foster Love

Disneyland, 1313 Disneyland Dr., Anaheim

- Sponsorship fee: $1,000; includes CalOptima Health flyers in gift bag.
- Health/Resource Fair, open to the public

November 7, 11 a.m.–3 p.m., Successful Aging in Place Resource Fair, hosted by Laguna Woods Village

Geneva Presbyterian Church, 24301 El Toro Rd., Laguna Woods

- Sponsorship fee: $250; includes resource table, ads in organizer directory, signage acknowledging sponsorship, recognition in all publicity and flyers.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

November 14, 9 a.m.–Noon, Katella High School and South Junior High School's 3rd Annual Community Resource Fair, hosted by the Anaheim Union High School District

Katella High School, 2200 E. Wagner Ave., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

November 14, 9–11:30 a.m., NAMI Walks Orange County 2026, hosted by NAMI

Angel Stadium, 2000 E. Gene Autry Wy., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

November 14, 9 a.m.–Noon, Family Preparedness Workshop and Resource Fair, hosted by County of Orange Supervisor Doug Chaffee

Fullerton Free Church, 2904 N. Brea Blvd., Fullerton

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

November 14, 9 a.m.–1:30 p.m., Golden Future Senior Expo, hosted by Golden Future Senior Expos

Sheraton Park Hotel, 1855 S. Harbor Blvd., Anaheim

- Registration fee: $1,650; includes agency name and hyperlink on website, exhibitor resource toolkit, email to attendees, 4 tickets, agency name and booth number frame sign, networking mixer, speaking opportunity/ workshop slot, promotional item in swag bags, profile and contact info printed in expo guide.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

November 17, 9 a.m.–5 p.m., Mobile Mammogram Event, hosted by CalOptima Health

Chapman Global Medical Center, 2601 E. Chapman Ave., Orange

- At least four staff members to attend
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

November 19, 3:30–4:30 p.m., CalOptima Health Medi-Cal Overview in English and Spanish

Hewes Head Start, 392 S. Hewes St., Orange

- At least one staff member to present
- Community-based organization presentation, open to members/community

November 21, 9 a.m.–1 p.m., Thanksgiving Food Distribution and Open House, hosted by CalOptima Health

CalOptima Health, 505 City Parkway West, Orange

- At least 20 staff members to attend (in person)
- Health/Resource Fair, open to the public

November 22, 10 a.m.–2 p.m., Feast of Gratitude, hosted by Moving Forward Psychological Institute

Garden Grove Friends Church, 12211 Magnolia St., Garden Grove

- Sponsorship fee: $1,500; includes resource table, logo on event signage, promotional materials, recognition on social media and in post-event thank-you messages.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

November 24, 9 a.m.–5 p.m., Mobile Mammogram Event, hosted by CalOptima Health

Orange Global Medical Center, 1001 N. Tustin Ave., Santa Ana

- At least four staff members to attend
- Health/Resource Fair, open to the public

November 26, 8–10:30 a.m., Y Give Thanks, hosted by the Anaheim Family YMCA

The Grove of Anaheim, 2200 E. Katella Ave., Anaheim

- Sponsorship fee: $10,000; includes resource booth, CalOptima Health branding on marketing materials and the stage banner, hourly sponsor announcements, and an opportunity to host an event altar.
- Health/Resource Fair, open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

26. Approve Actions Related to the Provider Workforce Development Initiative to Pilot a Provider Recruitment Incentive Program

Contact

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

Recommended Actions

1. Authorize an allocation of up to $5 million from the $50 million restricted Provider Workforce Development Fund to support the previously approved Provider Recruitment Incentive Program.
2. Authorize the Chief Executive Officer, or designee, to administer the Provider Recruitment Incentive Program.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

On June 1, 2023, the CalOptima Health Board of Directors (Board) approved the $50 million Provider Workforce Development Fund. The goals of the investment focused on identifying and addressing shortages and gaps in the Orange County health care workforce serving the Medi-Cal population, increasing the diversity of the health care workforce, and providing opportunities for education, training, recruitment, and retention of providers needed to serve CalOptima Health members in Orange County. CalOptima Health conducted stakeholder engagement, analyzed data, reviewed research and best practices, and proposed five initiatives that were approved by the Board on December 7, 2023.

	Proposed Initiative	Funding Type	Description	Current Status
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students.	Grants of $24.6 million awarded; implementation underway.

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	Proposed Initiative	Funding Type	Description	Current Status
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways.	Grants of $5.1 million awarded; implementation underway.
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps for primary and specialty care (includes psychiatry).	Planned launch January 2027.
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry and specific specialty gaps.	On Hold.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.	$0.3 million Completed; final report in development.

CalOptima Health has implemented the first two rounds of grant funding previously approved under the Provider Workforce Development initiative. Grantee projects are underway, and CalOptima Health staff are currently monitoring performance under these grant agreements. CalOptima Health awarded a total of $29.7 million to 13 entities for Provider Workforce Development activities.

In addition, CalOptima Health launched the Orange County Workforce Development Collaborative (Collaborative) and held three stakeholder meetings between April and June 2026. The Collaborative identified actionable solutions to address existing gaps and to inform strategies for the immediate development and long-term sustainability of the healthcare workforce in Orange County. Existing gaps identified include shortages in physicians and advanced practice providers (such as nurse practitioners and physician assistants) to address timely access to care; high turnover and retirement risk among existing providers; and limited recruitment and retention of specialty physicians, especially in safety-net settings. CalOptima Health allocated a total of $0.3 million to support this activity.

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The existing commitments total approximately $30 million, leaving an estimated balance of $20 million available to support additional Provider Workforce Development initiatives.

Discussion

To continue implementation of the Provider Workforce Development initiative, CalOptima Health staff is proposing an allocation of up to $5 million from the $50 million Provider Workforce Development initiative to pilot a Provider Recruitment Incentive Program (PRIP) that will address Medi-Cal provider shortages, as validated by the Collaborative. The findings also recommend focusing on support for qualified practice sites to hire physicians and advanced practice providers in primary care and select specialties. This program will aim to:

- Increase the number of clinicians serving CalOptima Health members in Orange County;
- Expand timely access to primary and specialty care; and
- Support practice sites to meet capacity demand due to growing needs of the Medi-Cal population.

CalOptima Health proposes to release an application that will allow eligible contracted practices and provider offices to apply for an incentive payment. This payment will fund recruitment expenses for hiring a new provider within their practice to serve Medi-Cal members. An initial investment of up to $5 million will allow for the recruitment of 20-29 new providers in Orange County over the next three years. CalOptima Health will provide incentive allocations in four incremental payments per hired provider and base payment amounts on the type of provider recruited as follows:

Total Incentive Payment per Recruited Provider	Provider Type
$150,000	Advanced Practice Provider - Nurse Practitioner or Physician Assistant
$175,000	Primary Care Physician
$200,000	Specialty Care Physician

Because this Provider Workforce Development initiative is focused on physician and advanced practice provider recruitment efforts, eligible provider types will include:

- Nurse Practitioner (NP)
- Physician's Assistant (PA)
- Doctor of Medicine (MD)
- Doctor of Osteopathic Medicine (DO)

CalOptima Health will target specialty care recruitment efforts to specialties where members experience access challenges based on network adequacy data, as listed below:

- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Hematology or Oncology
- Neurology

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- Obstetrics & Gynecology
- Otolaryngology or ENT
- Orthopedic Surgery
- Primary Care (adult/pediatric)
- Psychiatry
- Pulmonology
- Rheumatology
- Urology

CalOptima Health expects to hold two application cycles. The first application cycle will open in January 2027, with applications accepted and reviewed in February 2027. The second application cycle will open in July 2027, with applications accepted and reviewed in August 2027. CalOptima Health will utilize a standard scoring rubric to target investments in areas where there is the greatest need for increased access to care for Medi-Cal members. Staff will evaluate applications for funding based on the framework below:

Application Category	Application Review Criteria
Eligibility	• Eligible entities: Medical Groups, Federally Qualified Health Centers (FQHC), Community Clinics • Located in Orange County • Contracted with CalOptima Health • Serves the CalOptima Health Medi-Cal population • Medi-Cal licensed and fully credentialed (supervising physician) • Committed to hire and retain a new provider to serve CalOptima Health Medi-Cal members for a minimum of three years • Entity has capacity for growth and improved access
Provider to be Hired/ Recruited Provider	• Rationale for hiring a new provider • Provider type • Specialty type • Hired for a newly created position (If a new provider or recently hired, the provider must be employed within the last six months by qualified practice site) • Minimum required hours of direct patient care to CalOptima Health members – 20 hours/week
Project Implementation Plan	• Project plan with clear and complete implementation plan for recruitment/retention activities with well-defined project milestones and timeframes (including hiring the new provider within one year of award, training, and onboarding) • Implementation of appropriate mechanisms to monitor compliance with three-year minimum service period, including replacement of the funded position if the hired provider terminates employment before the end of three years

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Budget & Financial Management	• Budget and financial plan are sound and aligned with the objectives and timeline for the incentive payment • Outlines allocation of funds: salary and benefits subsidies, sign-on bonuses, and/or relocation costs (at least 50% of approved allocation used for salary and benefits subsidies)
Projected Program Outcomes	○ Number of providers to be hired ○ Improved patient capacity ○ Increase in new Medi-Cal patients served ○ Reduced wait time for appointments
Preferred Qualifications	• Provider to be hired has ability to provide culturally and linguistically competent care • Hired provider is early career or recent graduate • Provider is currently Medi-Cal-licensed and fully credentialed • Entity is a stable organization and in good standing with CalOptima Health (includes provider contract, free of contract sanctions and limitations, and absence of substantive corrective action)

CalOptima Health will conduct ongoing monitoring and oversight to ensure successful and appropriate delivery of program requirements and allocation of funds. Awardees will be required to submit documents including progress reports and budget tracking, which staff will review for completeness, timely submission, budget utilization, and alignment with the objectives outlined in the PRIP agreement.

Fiscal Impact

The recommended actions have no additional fiscal impact. The proposed $5 million allocation will be funded from the previously Board-approved $50 million Provider Workforce Development Fund. Upon approval of the proposed recommended actions, approximately $15 million will be available for future Provider Workforce Development initiatives.

Rationale for Recommendation

Approval of the $5 million allocation for the PRIP will help increase the supply of safety net providers serving CalOptima Health members in Orange County.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action December 7, 2023, “Approve Actions Related to the Workforce Development Strategic Priority”
2. Previous Board Action June 1, 2023, “Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund”

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Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 7, 2023	Approve Actions Related to the Workforce Development Strategic Priority	N/A	$10 million
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

22. Approve Actions Related to the Workforce Development Strategic Priority

Contacts

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981
Yunkyung Kim, Chief Operating Officer, (714)-923-8834

Recommended Actions

1. Approve the proposed program pillars for Provider Workforce Development initiative as:
    a. Educational Investments to Increase Supply of Health Care Professionals.
    b. Workforce Training & Development Innovation Fund.
    c. Physician Recruitment Incentive Program.
    d. Physician Loan Repayment Program.
    e. Orange County Health Care Workforce Development Collaborative.
2. Authorize the Chief Executive Officer, or designee, to issue an initial notice of funding opportunity for Educational Investments to Increase Supply of Health Care Professionals.
3. Authorize from the $50 million restricted CalOptima Health Provider Workforce Development Fund an allocation of up to $10 million to fund the grant agreements.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

In June of 2022, the CalOptima Health Board of Directors (Board) adopted the Strategic and Tactical Priorities for 2022-2025. The strategic priority areas and tactical priorities serve as the roadmap for strategic growth and funding allocations that support CalOptima Health's mission and vision. One strategic priority adopted by the Board was Future Growth, which includes the Member Access to Quality Care tactical priority. The $50 million Provider Workforce Development initiative, approved by the Board in June of 2023, supports the Member Access to Quality Care tactical priority among others.

Further, the goals of the initiative focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians; increasing the diversity of the health care workforce; and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

Discussion

As part of Workforce Development Initiative development, CalOptima Health sought input from community stakeholders, including educational institutions, providers, and community organizations. CalOptima Health sought feedback on several existing meetings and forums including the Member and Provider Advisory Committee, the monthly Health Network Forum, and other provider meetings.

CalOptima Health also hosted three public listening sessions with broad stakeholder attendance. Each listening session focused on a key stakeholder group: educational institutions, provider organizations, and community organizations. Stakeholders shared information on the barriers they have observed that drive the shortages in health care providers and health professionals in Orange County. Approximately 110 attendees participated in the listening sessions. Based on all outreach, CalOptima Health developed four categories of feedback that informed the areas targeted within this initiative.

1. Overall Healthcare Workforce Shortages

Healthcare workforce shortages and gap areas identified by provider and community partners in these meetings as well as through CalOptima Health provider network data include:

- Primary care (including physicians, physician assistants, and nurse practitioners).
- Nurses.
- Behavioral health professionals.
- Specialty care professionals specifically in the specialty areas of anesthesiology, cardiology, dermatology, endocrinology, gastroenterology, neurology, plastics, psychiatry, pulmonology, rheumatology, urology, and pediatric specialties.
- Allied health professionals.

2. Educational Institutions

Educational institutions shared their perspectives on the challenges they face in increasing the pipeline of students seeking health professions. Stakeholders indicated that there is no shortage of students who are interested in entering health professions in Orange County. The barriers to an increased pipeline of students are related more to available slots in existing programs and affordability of higher education. Barriers to increasing the number of slots in existing programs include a shortage of clinical rotation placements and a shortage of clinical faculty.

3. Provider Organizations

Provider organizations shared their perspectives on the challenges they face with recruitment and retention as well as the key workforce shortages in their systems. They cited competition for talent as well as high cost of living, burnout, and physician retirements as key challenges. In addition, comparatively lower reimbursement for Medi-Cal services can result in access barriers for CalOptima Health members.

4. Community Organizations

Community organizations shared broad feedback on the challenges they observe in Orange County related to health care workforce needs and shortages as well as their perspectives on how to increase diversity in the workforce. In every community stakeholder forum, behavioral health shortages and wait times were cited as a critical shortage area. In addition, stakeholders indicated the opportunities that exist within the community health worker workforce, the need for expanded access to culturally competent care and support, shortages of care coordinators/navigators, and emerging challenges due to growth in the aging population. In terms of increasing diversity of the health care workforce, key barriers cited include affordability of educational opportunities, the need for enhanced wraparound supports, internships and mentorships, and the need to connect community members to assistance and resources available in the community.

Proposed Program Initiatives

Based on stakeholder engagement, data analysis, and a review of research and best practices, CalOptima Health proposes a set of five initiatives for Provider Workforce Development Reserve Fund investment that address several of the key barriers to health care workforce expansion and retention in Orange County. CalOptima Health staff request an initial allocation of up to $10 million from the Workforce Development Fund for the first competitive grant program, as outlined in the table below.

	Proposed Initiative	**Funding Type**	**Description**
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students. *Notice of funding opportunity for Board approval.*
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways. *Notice of funding opportunity currently in development.*
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

Notice of Funding Opportunity for Educational Institutions to Increase Supply of Health Care Professionals

As noted above, there are two competitive grant opportunities proposed under the Workforce Development Initiative. CalOptima Health staff is seeking approval of up to $10 million for the first grant program under the outlined priority areas above for educational institutions to support investments in program expansion and student financial support.

Eligible applicants for grant funding under this opportunity would be educational institutions or partnerships among educational institutions and provider or community organizations. Potential activities that would be considered for funding under this opportunity include but are not limited to:

- Pipeline programs from high school into higher education with commitment to serve Orange County.
- Stipend programs with a commitment to serve Orange County.
- Funding to expand existing health care higher education programs to additional cohorts.
- Investments to expand clinical rotations to a greater number of students.
- Investments to develop and recruit faculty among health professions, including nurse educators, and others.

Potential types of programs that would be eligible for funding include, but are not limited to, nursing, allied health, and behavioral health. Future grant initiatives will be announced that focus on additional areas.

The notice of funding opportunity for this first round of competitive grants will be released on December 15, 2023. The application deadline for grant applications will be January 31, 2024. Awardees under the first round of grants will be presented for Board approval at the March 7, 2024 meeting of the Board, with grant awards planned for March 8, 2024 if approved.

Staff anticipates bringing an agenda item to the Board for review in April 2024 to approve the second round of competitive grants that will focus on the second identified priority initiative, Workforce Training & Development Innovation Fund.

Grants Management and Oversight
Staff will release each notice of funding opportunity in accordance with the CalOptima Health Policy AA.1400: Grants Management. Staff will return to the Board to request review and approval of recommended grantees. Specific milestones and reporting requirements and timelines will be developed as part of the grant award process.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted CalOptima Health Provider Workforce Development Fund in an amount not to exceed $50 million over five years. An allocation of up to $10 million from this restricted fund will support the recommended action.

Rationale for Recommendation

Approval of the proposed actions and the up to $10 million allocation from the $50 million total Workforce Development Fund will enable CalOptima Health to make investments to grow the health care workforce in Orange County to better serve CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action June 2, 2022, "Adopt Strategic and Tactical Priorities for 2022-2025"
2. Previous Board Action June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."
3. Notice of Funding Opportunity "Increasing the Health Care Workforce Pipeline Through Educational Investments."

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 2, 2022	Adopt Strategic and Tactical Priorities for 2022-2025		
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
18. Adopt Strategic and Tactical Priorities for 2022-2025

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action(s)
1. Adopt Strategic and Tactical Priorities for 2022-2025

Background and Discussion
CalOptima was created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS) to meet the needs or Orange County residents and providers in the Medicaid system.

In July of 1994, the CalOptima Board of Directors (Board) adopted the Mission, Goals, and Objective Statement for O.P.T.I.M.A as developed by the Provider Advisory Committee and the Consumer/Beneficiary Advisory Committee.

At that time, the Board wanted to ensure that the statement regarding the inclusion of the County-responsible indigent population in O.P.T.I.M.A was linked to the availability of adequate funding for services provided to this population.

The following mission was adopted and defined in Policy #AA. 1201:

- Mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima also adopted the following vision statement:

- To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

In 2013, during a strategic planning session conducted by the Board updating the mission was considered. Ultimately, it was agreed up on that the original mission statement did not require any changes.

Today, CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs:

- Medi-Cal
- OneCare
- OneCare Connect

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- PACE

On March 17, 2022, the Board formally adopted new mission and vision statements.

- Mission-To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision-By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Beginning in December of 2021, staff developed five strategic priorities and tactical priorities. Over the last six months, CalOptima has sought feedback from advisory committees, health networks, hospitals, and clinics among others. The five strategic priority areas are as follows:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountability and Results Tracking
- Future Growth

The strategic priority areas and tactical priorities will support planning and development for CalOptima through 2025. Staff will return to the Board with a Strategic Plan using these priorities for approval.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Development of the proposed Strategic Priority Areas is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Strategic Priorities One Pager
2. Resolution of New Mission and Vision Statement for CalOptima

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

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Mission	*To serve member health with excellence and dignity, respecting the value and needs of each person.*				
Vision	*By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.*				
Core Strategy	**The 'inter-agency' co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision.**				
Strategic Priorities 2022-2025	**Organizational and Leadership Development**	**Overcoming Health Disparities**	**Finance and Resource Allocation**	**Accountabilities & Results Tracking**	**Future Growth**
Tactical Priorities 2022-2025	• Cultural Alignment throughout CalOptima • Talent Development & Succession Planning • Effective & Efficient Organizational Structures • Aligned Operating Systems & Structures • Staff Leadership Development Institutes (Training) & Executive Coaching • Organizational Excellence Annual Priorities • On-going updated Policies & Procedures • Governance & Regulatory Compliance Trainings • Board Priorities	• CalOptima's 'Voice & Influence' • Local, Federal & State Advocacy • Collaboration with the County, HCA, BeWell, the Networks and Community Based Organizations • Support for Community Clinics & Safety Net Providers • Medical Affairs Value Based Care Delivery • CalAIM initiatives • Focus on Equity & Communities Impacted by Health Inequities • Co-Created Needs Assessment within Equity Communities & Neighborhoods • ITS Architecture that supports the Core Strategy • DHCS Comprehensive Quality Strategy	**Operating Budget Priorities** • Balanced Operating Budget • New Programs & Services Budgeting (CalAIM, DHCS Quality Strategy) • Fiscal Strategic Plan Priorities (KPI/KFI) • Quarterly Budget Reconciliation **Capital Budget Priorities** • Capital Planning & Asset Management, including Real-Estate Management and Acquisition(s) • New ITS Architecture **New Policy and Program Development based on Funding** • Reserve/Spending Policies & Priorities • Aligned Incentives for Network Quality & Compliance • Contracting & Vendor/Provider Management	• Updated By-Laws • Executive Priorities & Outcomes • COBAR Clarity • Inter-Agency Team Priorities • Public/Private Implementation Work Group • Resource Allocation for Inter-Agency Initiatives • Partner CalAIM Opportunities for Outcomes Metrics • Research Analytics for Efficacy Reporting (Metrics of Success) • Regular Board Training Sessions	• Member Access to Quality Care • Participate in Covered California • Site Utilization (PACE etc.) • Services/Programs Aligned with Future Reimbursements from DHCS and CMS • Demographic & Analytics by Micro-Community • ITS Data Sharing to benefit the member • Implement Programs & Services (CalAIM) & Plan for Site Locations • Industry Trends Analysis (Trade Associations, Lobbyists etc.) • Enhanced ITS security posture

DRAFT STRATEGIC AND TACTICAL PRIORITIES May_2022

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RESOLUTION NO. 22-0317-01

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

RESOLUTION FOR MISSION AND VISION STATEMENT

WHEREAS, the governing body of the Orange County Health Authority, dba CalOptima, ("CalOptima") adopted Mission, Goals, and Objective Statement O.P.T.I.M.A in July of 1994;

WHEREAS, this mission statement adopted in 1994 stated, the mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

WHEREAS, the adoption of the mission statement was reflected in Policy #AA. 1201;

WHEREAS, the governing body of CalOptima has adopted a new mission and vision statement on March 17, 2022 and will be reflected in Policy #AA. 1201;

WHEREAS, the governing body adopted CalOptima's new mission and vision statement as follows;

- Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision: By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

NOW, THEREFORE, BE IT RESOLVED that the governing body of CalOptima adopts a new mission and vision statement.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 17th day of March 2022.

AYES: Becerra, Chaffee, Contratto, Corwin, Do, Mayorga, Schoeffel, Shivers

NOES: None

ABSENT: Tran

ABSTAIN: None

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

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

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
22. Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund

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

Recommended Actions
1. Create a restricted CalOptima Health Provider Workforce Development Fund in the amount of $50 million from existing reserves to support the education, training, recruitment, and retention of safety net providers in Orange County;
2. Direct the Chief Executive Officer to create a 5-year Provider Workforce Development Plan for the local safety net provider community; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
The issue of health care provider shortages is one of the biggest challenges facing CalOptima Health and its community. In 2019, the California Future Health Workforce Commission projected that within 10 years, California would face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and would only have two-thirds of the psychiatrists it needs (Final Report of the California Future Health Workforce Commission, February 2019). Additionally, although California's population is becoming increasingly diverse, the health workforce does not reflect those demographics. These shortages and disparities are more pronounced in Medi-Cal, and projected workforce shortages have accelerated since the COVID-19 pandemic.

Discussion
CalOptima Health staff requests that the Board of Directors (Board) create a dedicated restricted reserve fund in the amount of $50 million to help address this looming crisis in the community. The funding will be used to create opportunities for education, training, recruitment, and retention of providers needed to serve CalOptima Health members.

Further, staff requests the Board to direct the Chief Executive Officer to develop a 5-year plan for local provider workforce development to include priority provider areas, funding strategies, and implementation plans for the Board's review and approval. CalOptima Health's plan will include learnings from existing statewide health workforce initiatives and engagement of local provider and member communities.

Fiscal Impact
An appropriation of up to $50 million from existing reserves will fund the restricted CalOptima Health Provider Workforce Development Fund.

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Rationale for Recommendation
The recommended action will support ongoing access to quality health providers for CalOptima Health's diverse membership.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
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Rationale for Recommendation
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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

27. Approve Material Changes to Grant Award Agreement with Orange County Health Care Agency for the Community Health Assessment and Community Health Improvement Plan

Contacts

Michaell Silva Rose, Chief Health Equity Officer, (657) 235-6757
Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Action

1. Approve material changes and amend the Grant Award Agreement with Orange County Health Care Agency related to the Community Health Assessment and Community Health Improvement Plan to do the following:
    a. Extend the Grant Award Agreement by 24 months through December 31, 2028, for a total term of 36 months;
    b. Add scopes of work for years two and three of the grant term; and
    c. Increase the grant award up to $904,465 for year two and up to $920,705 for year three.
2. Appropriate and allocate up to $1,825,170 in existing reserves to fund the amendment to the Grant Award Agreement with Orange County Health Care Agency through December 31, 2028.
3. Make a finding that such expenditures are for public purposes and in furtherance of CalOptima Health's mission and purpose.

Background

In 2023, the Department of Health Care Services (DHCS) launched the California Advancing and Innovating Medi-Cal (CalAIM) Population Health Management (PHM) Program as a statewide initiative designed to ensure all Medi-Cal members have access to a comprehensive set of services based on their needs and preferences.

The DHCS CalAIM PHM Program removed the requirement for Medi-Cal managed care plans (MCPs) to submit an annual Population Needs Assessment to DHCS. Instead, MCPs are now required to:

- Collaborate with Local Health Jurisdictions (LHJs) on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), including compliance with the LHJ CHA/CHIP timeline alignment; and
- Meaningfully participate with their LHJ in the development and implementation of the CHA/CHIP.

Starting in 2025, DHCS required MCPs to contribute funding and/or in-kind staffing resources to the LHJ to support the CHA/CHIP process. DHCS's goal is for MCPs to collaborate with local health departments, community-based organizations, and other stakeholders to better understand the needs and

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assets of the communities served and reduce siloed efforts to improve member health outcomes. MCPs are required to report meaningful participation activities to DHCS on an annual basis.

In Orange County, the LHJ is the Orange County Health Care Agency (OCHCA).

The CHA is a comprehensive analysis that identifies key needs and issues by engaging the community through surveys, focus groups, and the collection and review of existing and new countywide data. CalOptima Health, OCHCA, and external stakeholders collaborated to publish Orange County's CHA in October 2023.

The CHIP is the implementation plan based on CHA findings and was released in April 2024. The 2024 - 2027 Orange County CHIP identified six priority areas and workgroups that focused on mental health, substance use, diabetes and obesity, housing and homelessness, care navigation, and economic disparities.

The CHA/CHIP cycle is a continuous and ongoing process that assesses the community's health, implements targeted initiatives, evaluates the effectiveness of these initiatives, and measures outcomes. The Orange County CHIP implementation period will run from 2024 to 2027. In 2028, as mandated by DHCS, CalOptima Health and OCHCA will align CHA/CHIP process timelines and begin a new three-year cycle with a CHA.

On December 4, 2025, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to administer a one-year Grant Award Agreement with the OCHCA and award payment of up to $990,678.46 to support the implementation of the Orange County CHA and CHIP.

Discussion

OCHCA is successfully implementing the initial grant award from CalOptima Health, which has a scope of work and measurable objectives that involve development and execution of an implementation plan that: (i) convenes community-based committees to provide input on the CHA/CHIP efforts, (ii) deploys web-based support tools, (iii) conducts training to workgroups on the new tools, (iv) conducts outreach and communication on the progress of the CHA/CHIP efforts, and (v) provides technical assistance to related committees and workgroups.

As OCHCA gets deeper into developing a new CHA, and ultimately embarks on a new CHIP three-year cycle in 2028, CalOptima Health staff propose to extend its support to OCHCA by amending the grant to: (1) extend the Grant Award Agreement by 24 months for a total of 36 months; (2) add scopes of work for years 2 and 3 of the grant term; and (3) increase the total grant award up to $904,465 for year two budget and up to $920,705 for year three budget. Including the Grant Award Agreement's year one budget of $990,678.46, the new total of the grant award would be up to $2,815,848.46.

With Board approval, staff would like to proceed with the prompt development and execution of the grant amendment with OCHCA. Staff will provide oversight of the grant pursuant to CalOptima Health

Policy AA.1400: Grant Management and will return to the Board to provide updates on the status of the grant in future meetings.

Fiscal Impact

An appropriation of $1,825,170 from existing reserves will fund the Grant Award Agreement with OCHCA through December 31, 2028.

Rationale for Recommendation

This action to approve the material change to the Grant Award Agreement is recommended by the CalOptima Health Community Investment Committee to continue support of the mandated CHA/CHIP efforts.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by the Recommended Action
2. Grant Award Agreement, executed December 24, 2025

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 5, 2025	Authorize Actions Related to the Board Approved Initiatives Reserve Fund and Intergovernmental Transfer-Funded Initiatives	N/A	$9,886,905
December 4, 2025	Approve Actions Related to the Orange County Community Health Assessment and Community Health Improvement Plan		$990,678.46

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Attachment to the November 5, 2026 Board of Directors Meeting – Agenda #27

CONTRACTED / IMPACTED ENTITIES COVERED BY THE RECOMMENDED ACTION

Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 W 5th Street	Santa Ana	CA	92701

Information compiled by CalOptima Health staff on 10/22/2026

The list above only includes information that staff found through a search of publicly available information, and Directors should not solely rely on this list in determining whether a conflict of interest exists. Only a Director is aware of all their relevant interests under California law, and the California Fair Political Practices Commission ("**FPPC**") concluded that individual Directors are responsible for their own conflict determinations and advice (or lack of advice) from another party is not a defense for a violation. As such, this list is simply one tool that Directors may use in determining whether a conflict of interest exists. If a Director has a question about whether a specific interest is disqualifying, the Director should seek legal counsel to assist in making that determination.

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GRANT AWARD AGREEMENT

BETWEEN

CALOPTIMA HEALTH

AND

ORANGE COUNTY HEALTH CARE AGENCY

THIS GRANT AWARD AGREEMENT ("**Agreement**") is made and entered into as of January 1, 2026 ("**Effective Date**"), by and between Orange County Health Authority, a county organized health system for the County of Orange, California dba CalOptima Health ("**CalOptima**), and County of Orange, through its Health Care Agency ("**Grantee**"), a county government agency. CalOptima and Grantee may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a public agency formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

B. CalOptima's mission is to serve its members and look after their health with excellence and dignity, respecting the value and needs of each person.

C. The California Department of Health Care Services ("**DHCS**") CalAIM Population Health Management ("**PHM**") Policy Guide requires Grantee to conduct the Orange County Community Health Assessment ("**CHA**") and develop a Community Health Improvement Plan ("**CHIP**").

D. Grantee desires to coordinate the Orange County CHA/CHIP in accordance with Grantee's grant project described in Attachment A ("**Grant Project**").

E. CalOptima finds that the Grant Project is a community program that supports and is compatible with CalOptima's mission and that CalOptima desires to provide financial support for the Grant Project in the manner described in Attachment B ("**Grant Award**") and in accordance with CalOptima's policies and procedures, subject to Grantee's compliance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties hereto as follows:

I. GRANTEE OBLIGATIONS

1.1 **Grantee Eligibility**. Grantee hereby warrants that it is, and shall remain throughout the term of this agreement, a local public agency registered in California.

1.2 **Grantee Activities**. Grantee agrees (i) to diligently pursue the Grant Project, as specified in Attachment A, attached hereto and incorporated herein by this reference, (ii) to use the Grant Award solely for activities as identified in Attachment A, ("**Grant Activities**"), (iii) to expend funds in accordance with this Agreement and all federal, state, and local statutes and regulations, and (iv) to return any grant funds determined to have been improperly paid, in order to avoid forfeiture of the entire Grant Award. In the event of any conflict between the Grant Project in Attachment A and the rest of this Agreement, this Agreement, including all other Attachments, shall prevail.

1.3 **Unauthorized Use of Funds**. Grantee shall use Grant Funds in accordance with this Agreement, applicable laws, and the approved Grant Activities. CalOptima retains the right to recover any and all Grant Award funds if it (or any of its regulators) determines that (i) any portion of the Grant Award was not expended as provided under the terms of this Agreement, or (ii) Grantee did not comply with the Agreement or applicable federal and state laws, regulations, guidance and/or funding source requirements.

1.4 **Limitations on Subcontracting**. The experience, knowledge, capability, and reputation of Grantee, its directors and employees were a substantial inducement for CalOptima to enter into this Agreement. Grantee shall not contract with any entity to perform the Grant Project without written approval of CalOptima. Grantee shall be fully responsible to CalOptima for the acts and omissions of its subcontractor(s), if any, as it is for the acts and omissions of persons directly employed by Grantee. In the event that CalOptima approves any subcontracting, nothing contained in this Agreement shall create any contractual relationship between any subcontractor(s) and CalOptima. All persons engaged in the work under the Grant Proposal by Grantee will be considered employees of Grantee. CalOptima will deal directly with and make payment hereunder solely to Grantee.

1.5 **Subcontracts**. To the extent that subcontracting is authorized by CalOptima under this Agreement, Grantee shall assure that all subcontracts are in writing and include any requirements of this Agreement that are appropriate to the service or activity and assure that the subcontract shall not terminate legal liability of Grantee under this Agreement.

1.6 **Communications Provisions**. Grantee must comply with CalOptima's Guidelines for Endorsements and Use of CalOptima Name or Logo policy.

1.6.1 **Use of CalOptima name or logo**: Grantee shall submit requests to CalOptima's CalAIM department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name or logo is required. Upon receipt of a complete request for use of the CalOptima name or logo, CalOptima's CalAIM department shall review and analyze the request with input from appropriate internal departments. For more information or to submit a request, email calaim@caloptima.org. The CalAIM department shall submit a request for use of the CalOptima name or logo to the Communications Department for review and consideration and will notify Grantee in writing after a determination has been made.

1.6.2 **All other uses of CalOptima's name**: Grantees may not use CalOptima's name, including in the title of Grantee's program, without prior written approval from CalOptima.

1.6.3 **Use of Grantee's name or logo:** Grantee owns all rights to the name, trademarks, logos and symbols of Grantee. The use and/or reproduction of Grantee's name, trademark, logo and/or symbol for any purpose, including commercial advertisement, promotional purposes, announcements, displays or press releases, without Grantee's express prior written consent is expressly prohibited.

II. GRANT PAYMENTS

2.1 **Grant Payments**. Payment of the Grant Award to Grantee under this Agreement will be as set forth in Attachment B, incorporated herein by this reference, which shall be payment in full for the Grant Project. Grantee acknowledges and agrees that this is a single Grant Award and that nothing herein obligates CalOptima to any further funding, whether for the Grant Project or future related or unrelated activities. The Parties acknowledge that the source of Grant Award funding is Intergovernmental Transfer Funds (IGT), and not DHCS funds, and as such the payments made hereunder are not subject to DHCS State Contract terms or federal or state claims processing requirements.

2.2 **Grant Award Use Limitations**. Grantee acknowledges and agrees that the Grant Award may not be used for achievement of milestones that have been previously paid for or will be paid for by the state or federal government or any other source. Further, Grantee acknowledges and agrees that it will not use the Grant Award to reimburse costs or liabilities it incurred prior to the date of the Grant Award.

III. WARRANTIES/COMPLIANCE WITH CALOPTIMA AND REGULATORY AGENCY RULES AND REGULATIONS

3.1 **Compliance with Applicable Laws**. In carrying out the Grant Project, Grantee shall comply with the CalOptima policies and procedures and all other applicable CalOptima policies, as made available to Grantee on CalOptima website, as well as all applicable federal, state and local laws, rules, and regulations.

3.2 **Health Insurance Portability and Accountability Act (HIPAA) Compliance**.

3.2.1 Grantee and CalOptima shall comply with all applicable federal and state laws and regulations governing the privacy and security of health information, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act ("**CMIA**"), and any regulations promulgated thereunder ("**HIPAA Requirements**") in performing their obligations under the Agreement. The Parties acknowledge that the purpose of the Agreement is not to exchange, disclose, or access protected health information (as defined under HIPAA) or medical information (as defined under CMIA), and Grantee attests that it shall not disclose any protected health information or medical information under the Agreement. If Grantee inadvertently receives any protected health information or medical information during the term of the Agreement, Grantee shall promptly notify CalOptima and delete the information. If the Parties decide at a later date to expand the scope of the Agreement to include protected health information or medical information, the Parties shall amend this section to reflect that purpose and execute CalOptima's form business associate agreement, which CalOptima has made available to the Grantee, prior to disclosing or accessing any protected health information or medical information under the Agreement.

3.3 **Confidentiality of Information**.

3.3.1 Grantee and its employees, agents, and subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Grantee, its employees, agents, or subcontractors as a result of this Agreement. Grantee and its employees, agents, and subcontractors shall not use such identifying information for any purpose other than carrying out Grantee's obligations under this Agreement. Grantee and its employees, agents, and subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Grantee shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Member or in accordance with applicable law or court order, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, including without limitation a finger or voice print or a photograph.

3.3.2 Notwithstanding any other provision of this Agreement, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Welfare and Institutions Code Section 14100.2, and any regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Grantee from unauthorized disclosure. Grantee may release Member medical records in accordance with applicable law or court order pertaining to the release of this type of information. Grantee is not required to report requests for medical records made in accordance with applicable law or court order. With respect to any identifiable information concerning a Member under this Agreement that is obtained by Grantee, its employees, agents or subcontractors, Grantee:

(a) Will not use any such information for any purpose other than carrying out the express terms of this Agreement,

(b) Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for medical records in accordance with applicable law,

(c) Will not disclose except as otherwise specifically permitted by this Agreement, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 C.F.R. Section 431.300 et seq., Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and

(d) Will, at the termination of this Agreement, return all such information to CalOptima or maintain such information according to written procedures sent to the Grantee by CalOptima for this purpose.

3.4 **Conflicts of Interest**. No director, officer, employee, or Agent of Grantee may obtain a financial interest or benefit from the Grant Project, including any subcontracts, during their tenure with Grantee and for one (1) year thereafter. Grantee also represents and warrants that it does not have an existing financial or business relationship with any director, officer, or employee of CalOptima. Grantee and its members, officers, employees, agents, designees, and subcontractors will comply with all applicable laws and CalOptima policies regarding conflicts of interest, and Grantee shall incorporate, or cause to be incorporated, in all subcontracts relating to the Grant Project a provision that includes the requirements of this section. Grantee will immediately notify CalOptima of any violation of this Section 3.4.

IV. RECORDS AND REPORTS

4.1 **Maintain Complete Books and Records**. Grantee shall create and maintain such books and records relating to the Grant Activities performed under this Agreement as required by applicable laws and CalOptima policies and procedures. All financial records shall be maintained in accordance with generally accepted accounting principles ("**GAAP**"). Records generated in the course of carrying out this Agreement shall be maintained for ten (10) years from the date of the grant award, or the date of the completion of any audits related to this Agreement, whichever is later. Grantee shall provide CalOptima or its designated agents, within ten (10) calendar days of a written request, information or copies of records necessary to verify and substantiate compliance with the terms of this Agreement. Grantee shall pay all duplication and postage costs associated with any audits and/or reviews necessary to ensure compliance with this Agreement or CalOptima's regulatory requirements. This Section 4.1 shall survive the termination of this Agreement.

4.2 **Reports**. Grantee shall submit all reports as specified in Attachment C, "Grant Report Schedule," attached hereto and incorporated herein by this reference.

4.3 **Monitoring**. CalOptima shall have the right to perform Grant Program and fiscal monitoring of Grantee to ensure compliance with federal and state requirements and the terms of this Agreement, including auditing, or having audited by an independent third party, Grantee regarding the Grant Project, Grant Award, and related expenses. Grantee shall fully cooperate with CalOptima's monitoring under this section, including any CalOptima auditor. Grantee must resolve any monitoring findings to CalOptima's satisfaction by the deadlines set by CalOptima and refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures. Grantee shall be entitled to challenge any audit finding through appealing through CalOptima's grievance process.

V. INSURANCE AND INDEMNIFICATION

5.1 **Grantee Comprehensive General Liability ("CGL")/Automobile Liability**. Grantee at its sole cost and expense shall maintain a program of self insurance including coverage for general liability and automobile liability insurance to insure it against any claim or claims for damages arising by reason of (a) personal injuries or death occasioned in connection with the carrying out the project, (b) the use of any property of the Grantee, and (c) Grant Activities performed in

connection with the Agreement, with minimum coverage of one million dollars ($1,000,000) per incident/two million dollars ($2,000,000) aggregate per year.

5.2 **Workers Compensation Insurance**. Grantee at its sole cost and expense shall maintain a self insurance program of workers compensation insurance within the limits established and required by the State of California and employer's liability insurance with minimum limits of liability of one million dollars ($1,000,000) per occurrence/one million dollars ($1,000,000) aggregate per year.

5.3 **Captive Risk Retention Group/Self Insured**. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's and approves the waiver.

5.4 **Cancellation or Material Change**. The Grantee shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Agreement without prior notification to CalOptima.

5.5 **Certificates of Insurance**. Except to the extent waived pursuant to Section 5.4, prior to execution of this Agreement, Grantee shall provide Certificates of Insurance to CalOptima showing the required insurance coverage with respect to the performance hereunder.

5.6 **Indemnification**. Grantee shall defend, indemnify and hold harmless CalOptima and its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) that are related to or arise out of the Grantee's negligence, willful performance or non-performance or breach of any duties or obligations of Grantee arising under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release Grantee from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.7 **Notification of Claims**. CalOptima agrees to promptly notify Grantee of any claims or demands that arise and for which indemnification or Grantee's duty to defend hereunder is sought.

5.8 **Termination.** Sections 5.7 and 5.8 shall survive the termination of this Agreement.

VI. TERM AND TERMINATION

6.1 **Term of Agreement**. This Agreement will commence on last date of execution for the Parties and will remain in effect up to and including one (1) year from effective date ("**Termination Date**"), or completion of the Grant Project, whichever occurs first. CalOptima, in its sole discretion, may extend the term of the Agreement where the Grantee has not completed the Grant Project by the Termination Date. Grantee must request such an extension in writing, setting forth good cause for the request, prior to the Termination Date. If CalOptima opts to grant the term extension, it shall set forth

the terms and conditions of the extension in writing, including the duration of the extension and reporting requirements during the extension. If Grantee does not accept those terms and conditions, the Agreement will terminate on the Termination Date.

6.2 **Termination**. If Grantee fails to fulfill any of its duties and obligations under this Agreement, including but not limited to: (i) committing acts of unlawful discrimination; (ii) engaging in prohibited marketing activities; and, (iii) committing fraud or abuse relating to any obligation, duty or responsibility under this Agreement (such as falsifying data in any reports; failing to maintain eligible status (non-profit in good standing), etc.), CalOptima may terminate this Agreement for cause pursuant to Section 6.3.

6.3 **Termination for Cause**. Notwithstanding and in addition to any other provisions of this Agreement, CalOptima may terminate this Agreement for cause effective upon thirty (30) calendar days' prior written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 6.2. Grantee may appeal CalOptima's decision to terminate the Agreement for cause by filing a complaint pursuant to CalOptima policies and procedures. Grantee shall exhaust this administrative remedy, including requesting a hearing if permitted under CalOptima policies and procedures, for any and all Grantee complaints before commencing any civil action.

CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

6.4 **Automatic Termination**. This Agreement shall terminate automatically if the DHCS State Contract between CalOptima and DHCS is terminated.

6.5 **Bankruptcy**. CalOptima or Grantee may terminate this Agreement with thirty (30) day written notice to the other Party in the event (i) a petition is filed in a court of record jurisdiction to declare either Party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or (ii) if a trustee in bankruptcy or a receiver is appointed for such Party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) days thereof.

VII. GENERAL PROVISIONS

7.1 **Interpretation of Agreement Language**. CalOptima has the right to final interpretation of the Agreement language when disputes arise. Grantee has the right to appeal disputes concerning Agreement language to CalOptima.

7.2 **Waiver**. Any failure of a Party to insist upon strict compliance with any provision of this Agreement shall not be deemed a waiver of such provision or any other provision of this Agreement. To be effective, a waiver must be in writing that is signed and dated by the Parties.

7.3 **Assignment**. Neither this Agreement nor any of the duties delegated herein shall be assigned, delegated or transferred by Grantee without the prior written consent of CalOptima. CalOptima may assign this Agreement and its rights, interests and benefits hereunder to any entity

that has at least majority control of CalOptima or to any entity whose financial solvency has been approved by Grantee, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state and federal agencies.

7.4 **Independent Parties**. Grantee acknowledges that it is, at all times during the term of this Agreement, acting as an independent contractor under this Agreement and is not as an agent, employee, or partner of CalOptima. Grantee agrees to be solely responsible for all matters relating to compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any other taxes for such persons, including any related employer assessment or contributions required by law, and all other regulations governing such matters, and the payment of all salary, vacation and other employee benefits. At Grantee's expense as described herein, Grantee agrees to defend, indemnify, and hold harmless CalOptima, its directors, executives, officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of Grantee's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "**Employment Claim(s)**"). Grantee shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

7.5 **Integration of Entire Agreement**. This Agreement contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement that are not expressly set forth in this Agreement are null and void and of no further force or effect. All attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

7.6 **Independent Agreement.** Nothing in this Agreement shall affect any other contractual relationships between the Parties, such as an agreement for the provision of medical services to Members. No monies paid under this Agreement may be used for the provision of services that are payable under a different contract between the Parties, or for any other purpose beyond the Grant Project as set forth in Attachment A.

7.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

7.8 **Amendment**. CalOptima may amend this Agreement immediately upon written notice to Grantee in the event such amendment is required in order to maintain compliance with applicable state or federal laws; such amendments shall be limited to the minimum language necessary to comply with applicable state or federal law. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the Parties.

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7.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

7.10 **Choice of Law**. This Agreement shall be governed by and construed in accordance with the laws of the State of California. The Parties consent to the jurisdiction of the California Courts with venue in Orange County, California.

7.11 **Force Majeure**. Either Party shall be excused from performance hereunder for any period that a Party is prevented from meeting the terms of this Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war, but excluding labor disputes, (a "**Force Majeure Event**") provided such Party uses commercially reasonable efforts to mitigate its effects and gives prompt written notice to the other Party. The time for the performance shall be extended for the period of delay or inability to perform due to such occurrences up to a period of ten (10) days at which time the Party unaffected by the Force Majeure Event may immediately terminate this Agreement upon written notice to the other Party without liability.

7.12 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Agreement, and no implication shall be drawn against any Party by virtue of the drafting of this Agreement.

7.13 **Headings**. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

7.14 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Grantee hereby acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange, State of California, shall have no obligation or liability therefor.

7.15 **Non-liability of Officials and Employees of CalOptima**. No official or employee of CalOptima shall be personally liable to Grantee in the event of any default or breach by CalOptima, or for any amount that may become due to Grantee, or any obligation under the terms of this Agreement.

7.16 **Time of Essence**. Time is of the essence in the performance of this Agreement.

7.17 **Authority to Execute**. The persons executing this Agreement on behalf of the Parties warrant that they are duly authorized to execute this Agreement, and that by executing this Agreement, the Parties are formally bound.

7.18 **Counterparts**. This Agreement may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument.

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7.19 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such Party's address as set forth below or such other address provided by notice.

To: CalOptima Health
Attention: CEO
C/O: CalAIM
505 City Parkway West
Orange, California 92868

To: Grantee
Orange County Health Care Agency
Procurement & Contract Services
405 W. 5th St. Suite 600
Santa Ana, CA 92701

7.20 **Dispute Resolution**.

7.20.1 Meet and Confer. If either Party has a dispute arising under or related to this Agreement, the Parties shall informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 7.20.2.

7.20.2 Arbitration. Subject to the California Government Claims Act (Cal. Gov. Code §900 *et seq.*) governing claims against public entities, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Agreement shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express

agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

7.20.3 Exclusive Remedy. With the exception of any dispute that under applicable laws may not be settled through arbitration, arbitration under Section 7.20.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Agreement that is not resolved through the meet-and-confer processes.

7.20.4 Waiver. By agreeing to binding arbitration as set forth in Section 7.20.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

7.21 **Survival**. The following provisions of this Agreement shall survive termination or expiration of this Agreement: Sections 1.3 (Unauthorized Use of Funds), 1.6 (Communications Provisions), 3.3 (Confidentiality of Information), 4.1 (Maintain Complete Books and Records), 4.3 (Monitoring), 5.7 (Indemnification), 7.1 (Interpretation of Agreement Language), 7.2 (Waiver), 7.4 (Independent Parties), 7.7 (Invalidity or Unenforceability), 7.9 (No Waiver of Immunity or Privilege), 7.10 (Choice of Law), 7.12 (Interpretation), 7.20 (Dispute Resolution), and any other Agreement provisions that by their nature are intended to survive termination or expiration of this Agreement.

7.22 **Recitals and Exhibits**. The recitals and attachments to this Agreement are made a part of the Agreement by this reference.

VIII. SIGNATURES

IN WITNESS WHEREOF, the Parties have, by their duly authorized representatives, executed this Agreement, to be effective the date first written above:

FOR GRANTEE:

DocuSigned by:
Jennifer Sarin
C68DE55EB7AD4B4...
SIGNATURE

Jennifer Sarin
PRINT NAME

Director of Public Health and Nursing Services
TITLE

12/24/2025
DATE

APPROVED AS TO FORM
Office of the County Counsel
Orange County, CA
By: Signed by:
Brittany McLean
D63D13AC012A4CC...
Brittany McLean

FOR CALOPTIMA:

Yunkyung Kim (Dec 24, 2025 14:11:33 PST)
SIGNATURE

Yunkyung Kim
PRINT NAME

COO
TITLE

12/24/2025
DATE

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ATTACHMENT A
Grant Project

Grantee agrees to implement the agreed upon scope of work as described in this Attachment A.

I. Overview of the Grant Program.

This grant supports Grantee's implementation of a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP). A CHA is a comprehensive analysis that identifies key public health needs and issues through the review of local data. The CHA informs the development of the CHIP, a strategic roadmap for addressing priority health concerns identified by the community, that is implemented in the general population, including among CalOptima members.

II. OBJECTIVES

By the end of the Agreement, Grantee will facilitate implementation of the CHA/CHIP process, which serves as a shared plan to guide collective action by community members, organizations, agencies, health systems, and other local leaders, with the goal of improving health outcomes across Orange County.

This grant will support the Grantee in achieving the following objectives by the end of the grant period:

1. Within 60 days of grant agreement execution, develop a12-month Implementation Plan with timeline and objectives for the CHA/CHIP process that incorporates California Department of Public Health (CDPH) requirements. If one is already created for CDPH purposes, CalOptima will accept a copy of that plan.
2. Ensure that 100% of Implementation Plan (referenced in objective 1) milestones are executed, tracked and reported on through dedicated administrative and project management support.
3. Convene a Population Health Collaborative Steering Committee to meet quarterly (for a total of four) and the OC-CHIP Steering Committee to meet quarterly (for a total of four), per CHA/CHIP charter guidelines to guide implementation and decision-making.
4. Deploy web-based data visualization tools and conduct one training session with each of the six CHIP Implementation workgroups on data sharing and analysis.
5. Ensure community participation in four quarterly CHA/CHIP meetings by offering support such as food and bus tickets to ensure at least five community representatives attend each.
6. Publish at least two communication products (e.g., media posts, success stories, or newsletters) to promote CHA/CHIP awareness and progress.
7. Provide technical assistance (such as the MAPP tool or other technical resources) during monthly meetings with local health jurisdictions, managed

care plans, OC-CHIP Steering Committee, and CHIP Implementation workgroups.

Through this partnership, CalOptima and Grantee aim to align resources and efforts to advance health equity and improve the well-being of all who call Orange County home.

III. SCOPE OF WORK

1. GRANTEE'S ROLE/RESPONSIBILITIES

Grantee will provide collaborative opportunities to CalOptima in support of CalOptima's compliance obligations with DHCS CalAIM PHM requirements and lay the groundwork for a unified Community Health Improvement Plan (CHIP) in 2028, in alignment with DHCS PHM requirements. This work will be facilitated through the development of structures, processes, and relationships that enable a single, collaborative CHIP to be created by Grantee, Medi-Cal Managed Care Plans operating in Orange County, any electively participating non-profit hospitals or health agencies, as well as additional community partners.

Activities may include:

- Shared governance development and planning
- Stakeholder engagement
- Data collection, analysis and asset mapping
- Cross-sector collaboration and capacity building
- Community-centered planning and implementation

2. CALOPTIMA'S ROLE/RESPONSIBILITIES

CalOptima shall provide financial and technical support for the CHA/CHIP process, as well as:

a) Supporting outreach to Medi-Cal stakeholders, providers, and members;
b) Identifying and engaging internal and external partners in the CHA/CHIP Process, including, but not limited to the:
    a. Member Advisory Committee
    b. Provider Advisory Committee
    c. Population Health Committees
    d. Other governing and advisory bodies.
c) Sharing relevant CalOptima data to support the CHA;
d) Participating in shared governance and planning bodies; and
e) Supporting and participating in implementation of strategies aligned with PHM requirements and identified priorities.

3. DELIVERABLES

Grantee must lead and complete the CHA and CHIP processes, including all activities described in Section III.1. The following deliverables must be submitted to CalOptima and produced by Grantee:

a) Within 60 days of grant execution, provide the Implementation Plan as referenced above, which includes:
    a. A timeline of key activities and milestones based on objectives
    b. Designated responsible parties
    c. Initial milestones, including but not limited to:
        i. Sharing of quantitative and qualitative data on health outcomes and disparities across agencies;
    d. Establishment or adoption of a CHA/CHIP Governance Body within one month of grant execution, with meetings held at least quarterly.
b) Grant reporting required per Attachment C.

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ATTACHMENT B
Grant Payment

CalOptima has made a Grant Award to Grantee in the amount of nine hundred and ninety thousand, six hundred and seventy-eight dollars and forty-six cents ($990,678.46), which shall be the maximum amount payable for the Grant Project and which shall be paid following execution of the Agreement in the time and manner set forth below.

Payments: Payments under this Agreement shall be made in two installment according to the schedule listed below. The first payment will be made upon Agreement execution. The final payment is contingent upon CalOptima's receipt and approval of the mid-year progress report and line-item budget report for the Grant Project. Such report and budget must be acceptable to CalOptima and demonstrate progress toward Grant Project. CalOptima may delay or withhold Grant Award payments at its sole discretion if such report and/or budgets are not submitted timely or as otherwise required or if CalOptima is not satisfied with any submitted reports/budgets and/or Grantee's progress on Grant Project objectives.

If Grantee's actual Grant Award expenditures are expected to vary by more than ten percent (10%) ("**Variation Threshold**") from any CalOptima-approved line-item budget entry, Grantee must obtain prior written approval from CalOptima before spending any amount of the Grant Award in excess of the Variation Threshold. Failure to obtain CalOptima's prior written approval for expenditures in excess of the Variation Threshold shall constitute a breach of the Agreement and entitle CalOptima to recoup some or all of the Grant Award, in its sole discretion.

In addition, CalOptima shall only issue the Final Payment of the Grant Award after Grantee has timely completed its Grant Project objectives to date and met all its reporting obligations under the Agreement, and spent a minimum of eighty percent (80%) of the Grant Award previously received from CalOptima under this Agreement. CalOptima may withhold or reduce Grant Award payments, in its sole discretion, if Grantee has not spent a minimum of eighty percent (80%) of the Grant Award previously received from CalOptima in accordance with the Agreement requirements, including the Grant Project description in Attachment A.

Payment Schedule:

Initial Payment of $495,339.23 upon Agreement execution.

Final Payment of $495,339.23 contingent upon submission to and approval by CalOptima of the six month grant narrative and budget report and expenditure of at least 80% of payment #1.

Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with the requirements of this Agreement, including Section III of

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Attachment A. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award, including where Grantee breached the Agreement, within thirty (30) days of the notice of such improper expenditures. The potential recoupment of Grant Award funds pursuant to this section is in addition to, and not in lieu of, any other rights and remedies of CalOptima under this Agreement.

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ATTACHMENT C
Grant Report Schedule

Purpose of Grant Reports

In an effort to help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress through monthly meetings with Grantee and requires that Grantee submit a final report. These reports are intended to help both CalOptima and Grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through written communication with CalOptima's Grant Management Department. Please note that successful completion of reports are a condition of grant funding and incomplete reports will delay the disbursement of future grant payments, if multiple payments are being dispersed.

The Grantee shall make every reasonable effort to complete all project activities and appropriate expenditures as defined in Attachment A by the Term Date specified in the Grant Award Agreement. The Grantee shall provide a final report to CalOptima within thirty (30) days after the program end date so that the report may be audited and approved for final payment. If the deadline cannot be met, a written explanation and the new anticipated date of completion must be provided to CalOptima. CalOptima will allow up to ninety (90) days from the Term Date for full closeout phase, which includes necessary reviews to successfully close out the grant.

Report Submission Schedule

CalOptima Health will provide the Grantee with narrative and budget reporting forms for the following reporting requirements. This grant requires the submission of two reports over the duration of the project timeframe as follows:

- **Semi-Annual Progress Report**
  - Specific due dates and Reporting Periods Covered:
    - Report #1 Due July 30, 2026 covering January 1, 2026 – June 30, 2026.

- **Final Report** will be due within thirty (30) calendar days after the end of this Grant Agreement.
  - Specific due date and Reporting Period Covered:
    - Report #2 Due January 30, 2027 covering January 1, 2026 – December 31, 2026.

CalOptima may require additional reporting from the Grantee during the term of the Agreement, as CalOptima determines in its sole discretion.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 5, 2026
Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

28. Approve Extension of the Skilled Nursing Facility Access Program

Contacts

Zeinab Dabbah, Deputy Chief Medical Officer, 657-900-1481
Kelly Giardina, Executive Director, Clinical Operations, 657-900-1013

Recommended Action

1. Authorize a three-year extension of the Skilled Nursing Facility (SNF) Access Program through June 30, 2029.
2. Extend the authorization to use the remaining appropriated SNF Access Program funds through June 30, 2029, to continue implementation of the Southern California Hospitalist Network Pilot Program, conduct a new Bed-Leasing Pilot Program, and implement initiatives to increase bed capacity in SNF and subacute facilities.
3. Authorize the Chief Executive Officer, or designee, to negotiate and execute contracts and contract amendments with SNF and subacute facilities to increase bed capacity and facilitate transitions to lower levels of care.

Background

On December 1, 2022, the CalOptima Health Board of Directors (Board) authorized a three-year SNF Access Program and appropriated $10 million in funding to improve members' quality of care and experience by increasing access to SNF beds and strengthening the Orange County safety-net network. Implementation required a substantial ramp-up period. CalOptima Health spent nearly two years refining and operationalizing the program to ensure that its incentive structures, provider engagement strategies, and access pathways were appropriately designed.

As part of this work, CalOptima Health also launched a pilot with the Southern California Hospitalist Network (SCHN) to strengthen physician support for members during short-term skilled stays at participating SNFs. Effective March 16, 2026, SCHN began serving as the attending physician group for CalOptima Health Community Network (CHCN) Medi-Cal and OneCare members admitted to designated facilities. The SCHN Pilot Program aims to improve quality of care and reduce length of stay through aligned performance metrics.

Together, these SNF Access Program components focus on:

- Improving timely transitions from hospitals to SNFs;
- Expanding placement options for members with complex and behavioral health needs; and
- Ensuring members receive the right level of care at the right time through improved system throughput.

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The SNF Access Program also aims to relieve bottlenecks in hospitals, emergency departments, acute rehabilitation facilities, and long-term acute care settings by increasing system capacity and improving overall member flow.

Discussion

The existing term of the SNF Access Program was from July 1, 2023, through June 30, 2026. Staff seeks approval to extend the SNF Access Program for an additional three years through June 30, 2029. The extension will allow CalOptima Health to build on progress achieved under the original program and implement new strategies to improve member placement following hospital discharge.

Since the SNF Access Program began, medical management has incorporated many program activities into ongoing clinical workflows. This approach has enabled critical care coordination and placement activities to be supported through medical expenses rather than operational or incentive funding. As a result, a substantial portion of the original $10 million appropriation authorized by the Board on December 1, 2022, remains available. Staff therefore seek to extend the SNF Access Program and leverage the remaining funds to support initiatives that further improve member access, quality, and system capacity.

Current Initiative: SCHN Pilot Program

The proposed extension supports the continuation of the SCHN Pilot Program and provides flexibility for future expansion. The SCHN initiative extends SCHN's hospital-based model to SNFs, with the goals to:

- Deploy dedicated physician groups to support members during short-term skilled stays;
- Enhance clinical oversight and improve member outcomes; and
- Reduce length of stay through aligned performance metrics and coordinated care models.

Because the SNF Access Program funds the SCHN Pilot Program, continuation of the programs is essential to maintaining momentum and evaluating long-term outcomes. Preliminary estimates indicate that the existing SCHN Pilot Program could require up to approximately $1 million during the proposed three-year extension period. As performance metrics mature and additional facilities are considered for participation, future funding needs may increase if the model is expanded to additional physician groups or participating facilities.

Proposed Initiative: Bed-Leasing Pilot Program

To further strengthen system capacity, staff proposes a pilot Bed-Leasing Pilot Program to secure dedicated beds in SNFs and subacute facilities for CalOptima Health members transitioning from acute care settings. The Bed-Leasing Pilot Program may begin with a high-performing facility partner and may expand to additional facilities as operational needs evolve. Dedicated beds would:

- Support timely placement;
- Reduce length of stay;
- Ease bottlenecks in hospital and long-term acute care transitions; and
- Help decompress hospitals by enabling faster transitions.

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The proposed Bed-Leasing Pilot Program is estimated to cost approximately $1 million over three years for an initial subacute facility and could expand to additional facilities as operational needs warrant. Expansion to as many as three subacute facilities could increase total SNF Access Program costs to approximately $3 million, subject to negotiated rates and available capacity.

Future Capacity Initiatives and Emerging System Needs

Staff will seek additional opportunities to strengthen post-acute capacity, reduce avoidable hospital utilization, and support member transitions across the continuum of care.

As part of the proposed extension, staff requests authority for the Chief Executive Officer (CEO), or designee, to negotiate and execute new contracts and contract amendments with SNF and subacute facilities as needed to support the SNF Access Program. This authority will enable CalOptima Health to respond efficiently to emerging capacity needs, implement future initiatives, expand successful pilots, and strengthen partnerships that improve member access and care transitions.

Additionally, anticipated impacts associated with H.R. 1 implementation may increase emergency department utilization and place further strain on hospital capacity throughout Orange County. CalOptima Health will pursue future initiatives to address evolving system needs and invest in strategies that strengthen post-acute capacity, improve hospital throughput, and ensure members receive timely care in the most appropriate setting.

Fiscal Impact

The recommended actions have no additional fiscal impact. A previous Board action on December 1, 2022, appropriated up to $10 million from existing reserves to fund the SNF Access Program. Staff will continue to implement the SNF Access Program within the approved funding allocation through June 30, 2029.

Rationale for Recommendation

SNF and subacute bed shortages continue to pose challenges for hospitals, emergency departments, and other settings in delivering appropriate care at the right time and level. Extending the SNF Access Program and empowering the CEO to execute and amend contracts will:

- Maintain momentum;
- Strengthen the safety net for members with complex needs;
- Promote timely placements; and
- Build on the early progress of the SCHN Pilot Program to create a larger impact.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Board-Approved Initiative Status and Impact Summary (SNF Access Program)
2. 12/1/2022 Board Action: Authorize Actions Related to Improving Member Quality and Experience of Care Through Better Access to Skilled Nursing Facilities

Board Action(s)

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Authorize Actions Related to Improving Member Quality and Experience of Care Through Better Access to Skilled Nursing Facilities	July 1, 2023 - June 30, 2026	$10 million

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CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	7/9/2026	**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:	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 Skilled Nursing Facility (SNF) Access Program aims to enhance quality through better access and further strengthen the safety net system across Orange County for medically complex individuals transitioning from the hospital to home, or from one care setting to another. It will establish a dedicated Skilled Nursing Facility team. The goal is to assist in recovery by providing the necessary nursing and rehabilitative care to help members regain independence and facilitate safe discharge.	- Held monthly coordination with Southern California Hospitalist Network (SCHN) leadership to ensure alignment and progress and weekly rounds with SCHN to improve case tracking and streamline handoffs. Coordinated cross-functional workflows to resolve process gaps and improve documentation consistency. - Delivered kickoff at March Hospital Transitions of Care CEO Forum to educate on the program. - Held education session with facilities and SCHN to align expectations and operational workflows. - Identified lack of access for Medi-Cal members through Point Click Care for SNF. Plan to expand access utilizing a portion of the initiative funding. First incentive payment expected 9/2026. Need to extend the end date of the initiative to 12/31/2028.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Launch SNFist program to contracted Facilities	Contract with SNFist group	- Contract Amendment completed 2/18/26, effective 3/1/26. Pilot formally launched on 3/16/26; 19 facilities participating. -Implemented a Value based contract with Southern California Hospitalist Network (SCHN).
Reduce length of stay (LOS) at SNF to allow for increased bed capacity	Reduce SNF LOS to average LOS of 14 days or less (current 24) at participating SNFs	SCHN provided care for 98 unique members with an average length of stay of 13.5 days (Preliminary Data).
Reduce unnecessary hospital readmissions	Reduce Average Hospital Readmission Rate from SNF to less than 14% per quarter	TBD

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

26. Authorize Actions Related to Improving Member Quality and Experience of Care Through Better Access to Skilled Nursing Facilities

Contacts

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Recommended Actions

1. Authorize the Chief Executive Officer to develop and execute a three (3)-year skilled nursing facility Access Program, from July 1, 2023, through June 30, 2026;
2. Authorize the Chief Executive Officer to amend contracts to implement the Skilled Nursing Facility Access Program;
3. Authorize appropriation of funds in the amount of up to $10 million from existing reserves to fund the Skilled Nursing Facility Access Program over the three (3)-year period; and
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background and Discussion

CalOptima Health proposes to launch a three (3) year, up to $10 million-dollar program with Skilled Nursing Facilities (SNFs) to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post hospitalization care.

Placing a CalOptima Health member in a SNF can incur significant delay, from weeks to months, due to the inability to secure a SNF bed. SNFs form the bridge for members who no longer require acute care in a hospital setting, but still require skilled care and services. SNFs are often the only option for continued medical care for these complex members. SNFs contribute to the safety net system by creating a path to lower levels of care for members who may still need close monitoring and supervision for medical treatment, personal, and behavioral care. Further, moving members from the hospital setting to a SNF frees up needed hospital beds for more acute patients for the entire Orange County community. These complex members often present with few social supports and require additional, intense case manager coordination, and oversight to assist members to effectively transition to a SNF. CalOptima Health's complex members often have significant behavioral health issues making SNF placement very difficult. In summary, these factors have resulted in substantial issues delaying timely discharge from emergency departments, hospitals, acute rehabs, and long-term acute health care (LTAC) facilities all of which impacts upstream bed resources.

CalOptima Health staff propose a three (3)-year program with CalOptima Health contracted SNF's. The program will assist acute care facilities with safe discharges to SNFs by:

1. Improving timely transitions from acute settings to SNF level of care by improving bed availability at SNF's.

2. Enhancing and strengthening safety net placement options for members with complex and behavioral health needs.
3. Enhance quality through better access to SNF's.

The initiative will be structured to provide up to $10 million over a three (3)-year period. Funding distribution over the period will be focused on improving system throughput and bed availability.

Fiscal Impact
An appropriation of up to $10 million from existing reserves will fund the SNF Access Program from July 1, 2023, through June 30, 2026. Management will include expenses in future operating budgets.

Rationale for Recommendation
SNF bed unavailability creates a challenge for hospitals, emergency departments, and LTACs to ensure members receive the right care at the right level at the right time. Working with CalOptima Health's SNF providers will enhance the safety net for these complex members who require timely SNF placement and continued medical care. Through the SNF Access Program, CalOptima Health seeks to ensure that the SNFs remain strong quality partners in care for all CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**