



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

**THURSDAY, OCTOBER 1, 2026
2:00 P.M.**

**505 CITY PARKWAY WEST
ORANGE, CALIFORNIA 92868**

**TELECONFERENCE LOCATION:
PROVIDENCE HEALTH & SERVICES OFFICE
1801 LIND AVENUE SW
RENTON, WASHINGTON 98057**

BOARD OF DIRECTORS

Supervisor Vicente Sarmiento, Chair
Isabel Becerra
Norma Garcia Guillen
Brian Helleland
(Vacant)

Maura Byron, Vice Chair
Blair Contratto
Catherine Green, R.N.
Veronica Kelley, DSW, LCSW
Supervisor Janet Nguyen

Supervisor Doug Chaffee, Alternate

CHIEF EXECUTIVE OFFICER
Michael Hunn

OUTSIDE GENERAL COUNSEL
James Novello
Kennaday Leavitt

CLERK OF THE BOARD
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

None.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

ADVISORY COMMITTEE UPDATES

None.

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. Meeting Minutes

Recommended Action:

- 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

Recommended Action:

- 1. Reappoint Rodney Johnson to the Investment Advisory Committee for a two (2)-year term, beginning October 6, 2026, and continuing until October 5, 2028; and
- 2. Reappoint Rodney Johnson to serve as Chair of the Investment Advisory Committee for a two (2)-year term, beginning October 6, 2026, and continuing until October 5, 2028, or until a successor is appointed.

4. Approve Reappointments to the CalOptima Health Board of Directors' Investment Advisory Committee

Recommended Action:

Reappoint the following individuals to the Board of Directors' Investment Advisory Committee for two (2)-year terms beginning October 6, 2026, and continuing until October 5, 2028:

1. Colleen Clark; and
2. David Hutchison.

5. Adopt Resolution No. 26-1001-01 Approving Updated CalOptima Health Human Resources Policies

Recommended Action:

Adopt Resolution No. 26-1001-001 approving updated CalOptima Health policies effective October 1, 2026:

1. CalOptima Health Policy AA.1252: Workforce Engagement and Opportunity;
2. CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention;
3. CalOptima Health Policy GA.8036: Education Reimbursement; and
4. CalOptima Health Policy GA.8050: Confidentiality.

6. Approve CalOptima Health Pharmacy Management Policies Related to Covered California

Recommended Action:

Approve pharmacy management policies and procedures to reflect new operational requirements for CalOptima Health's Covered California product, effective January 1, 2027:

1. CalOptima Health Policy CC.1903: Physician Administered Drug (PAD) Prior Authorization Process; and
2. CalOptima Health Policy CC.1904: Notification Regarding Medication Recalls.

7. Approve CalOptima Health Operations Policies Related to Covered California

Recommended Action:

Approve policies and procedures developed or updated to reflect operational requirements for CalOptima Health's Covered California product, effective January 1, 2027:

1. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint;
2. CalOptima Health Policy CC.1200: Member Appeal Process;
3. CalOptima Health Policy CC.1201: Member Grievance;
4. CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment;
5. CalOptima Health Policy DD.2005: Member Informing Materials Requirements;
6. CalOptima Health Policy DD.2001: Member Rights and Responsibilities; and

7. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

8. Approve CalOptima Health Network Management Policies Related to Covered California

Recommended Action:

Approve health network management policies and procedures to reflect new operational requirements for CalOptima Health's Covered California product, effective November 1, 2026:

1. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment

9. Approve Revisions to CalOptima Health's Community Relations Policies

Recommended Action:

Approve revisions to the following CalOptima Health community relations policies and related attachments, effective October 1, 2026:

1. CalOptima Health Policy AA.1214: Guidelines for Letters of Support and Use of CalOptima Health Name or Logo; and
2. CalOptima Health Policy AA.1223: Participation in and Sponsorship of Community Events by External Entities.

10. Approve Modifications to Utilization Management Policies GG.1500 and GG.1508

Recommended Action:

Approve modifications to CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and CalOptima Health Policy GG.1508: Authorization and Processing of Referrals, effective October 1, 2026.

11. Approve Modifications to Long Term Services and Supports Policy GG.1503

Recommended Action:

Approve the modifications to CalOptima Health Policy GG.1503: CalOptima Health Hospice Coverage, Notification and Validation Requirements pursuant to the Department of Health Care Services guidance, effective October 1, 2026.

12. Approve CalOptima Health Clinical Operations Policies Related to Covered California

Recommended Action:

Approve policies and procedures developed or updated to reflect operational requirements for CalOptima Health's Covered California product, effective January 1, 2027:

1. CalOptima Health Policy GG.1667: Population Health Management Program;
2. CalOptima Health Policy GG.1201: Health Education Program;
3. CalOptima Health Policy GG.1708: Disease Management Program;
4. CalOptima Health Policy GG.1701: Maternity Services for Pregnant and Postpartum Members;
5. CalOptima Health Policy GG.1704: Breastfeeding Promotion
6. CalOptima Health Policy GG.1707: Doula Services
7. CalOptima Health Policy GG.1301: Comprehensive Care Management Process

8. CalOptima Health Policy CC.2100 (New): CalOptima Health Covered Health Assessment and Case Management

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

DISCUSSION ITEMS

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

Recommended Action:

Accept, receive, and file the Fiscal Year 2025-26 CalOptima Health consolidated audited financial statements as submitted by independent auditors, Baker Tilly US, LLP.

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

Recommended Action:

Approve the Revised CalOptima Health Medi-Cal Fiscal Year 2026-27 Operating Budget and authorize expenditures and appropriate funds for the items in Revised Attachment A: Revised Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items.

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

Recommended Action:

Authorize 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.

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

Recommended Action:

Approve the adoption of the Funding Priorities Framework for purposes of CalOptima Health’s grantmaking activities.

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

Recommended Action:

1. Authorize 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 Enrollment Academy and a Work and Community Engagement Requirement Navigation Service Program.
2. Authorize 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.
3. Allocate 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 Enrollment 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.

20. Approve New CalOptima Health Provider Contract Termination Policy EE.1142

Recommended Action:

Approve new CalOptima Health Policy EE.1142: CalOptima Health Provider Contract Termination, effective October 1, 2026.

CLOSED SESSION

CS-1 CONFERENCE WITH REAL PROPERTY NEGOTIATORS – GOVERNMENT CODE SECTION 54956.8

Property: 1 7838 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

DISCUSSION ITEMS CONTINUED

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

Recommended Action:

Authorize, 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.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT



**NOTICE REGARDING
PUBLIC ATTENDANCE & PARTICIPATION AT PUBLIC MEETINGS
Board of Directors Meeting
Thursday, October 1, 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: 968 2422 3947
Passcode: 036852

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	+1 564 217 2000	+1 309 205 3325
+1 669 444 9171	+1 646 931 3860	+1 312 626 6799
+1 719 359 4580	+1 689 278 1000	+1 360 209 5623
+1 253 205 0468	+1 929 205 6099	+1 386 347 5053
+1 253 215 8782	+1 301 715 8592	+1 507 473 4847
+1 346 248 7799	+1 305 224 1968	<u>International Numbers</u>

Webinar ID: 968 2422 3947

Passcode: 036852

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!



MEMORANDUM

DATE: September 24, 2026

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — October 1, 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. Since receiving provisional approval from the California Department of Managed Health Care (DMHC) on August 11 for our Knox-Keene Act license material modification, staff continues to respond to three final items within the DMHC filing. On September 17, DMHC approved the CalOptima Health Covered awareness advertising campaign materials. As such, our general awareness marketing campaign has now launched in the community. Staff also continues to engage with Covered California's contract managers, and the first phase of system testing between Covered California and CalOptima Health is nearly complete. In addition, staff continues to develop educational materials for member and broker audiences and held a broker kick-off event on September 23 to educate brokers on CalOptima Health Covered in advance of open enrollment, which begins on November 1. Finally, operational implementation activities are progressing with a targeted focus on open enrollment readiness. Based on information shared by Covered California, CalOptima Health is preparing to receive enrollment files for renewing Covered California enrollees with January 2027 effective dates as early as October 2. Staff is conducting daily meetings to monitor all readiness activities.

B. CalOptima Health Medi-Cal Earns 4 Stars in NCQA Quality Rating

On September 16, the National Committee for Quality Assurance (NCQA) released its ratings of Medicaid plans nationwide on quality of care, member experience with their care and quality processes. NCQA aggregates these factors into a health plan rating on a scale of 1 to 5 stars. CalOptima Health Medi-Cal's 2026 rating is 4 stars, an increase from the prior rating of 3.5 stars. The rating reflects care delivered in 2025. The lower rating in 2025 was due to a 0.5-point decrease in overall points, which meant we barely missed the 4-star threshold. We take the quality of members' care seriously, and in response to last year's score, we implemented ongoing initiatives to improve the identified areas with declining performance. Our performance improved meaningfully through a data-driven, member-centric approach that expanded at-home care models and deepened collaboration with providers and health networks. We launched Cozeva PayerOne to obtain the most accurate, complete data possible, strengthened our data foundation by securing historical lab results from partners, and significantly improved our ability to capture evidence of services already provided through monthly supplemental

data collection efforts. We also expanded our at-home testing program to include multiple quality measures, including colorectal cancer screening and diabetes-related measures. CalOptima Health was one of nine plans statewide to achieve a 4-star rating, with only four plans getting above a 4-star rating.

C. California State Legislature Adjourns 2025–26 Session

On September 1, the California State Legislature formally adjourned the 2025–26 legislative session. During the final two days of session, the state legislature passed several budget-related bills to amend the Fiscal Year (FY) 2026–27 state budget that was enacted earlier this summer. The following is a summary of the two bills impacting the Medi-Cal program:

AB 113: Budget Bill Jr.:

- Clarifies that the \$31 million previously allocated to the Department of Health Care Services (DHCS) for care coordination services to support the transition of Unsatisfactory Immigration Status (UIS) beneficiaries from Medi-Cal managed care plans (MCPs) to the Medi-Cal fee-for-service (FFS) system is 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.

AB 173: Health Trailer Bill Jr.:

- 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. QNC populations include 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.
- Requires DHCS and the California Department of Aging to examine Community-Based Adult Services (CBAS) center closures and their impact by March 1, 2029.
- Expands DHCS authority to take the following actions to improve Medi-Cal provider oversight and program integrity:
 - 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).
 - Temporarily suspend providers under investigation for FWA and make suspensions effective more quickly.
 - Impose provider enrollment moratoria, including removing existing exemptions for certain clinics and health professionals.
- 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.

Notably, these bills did not include the proposal by the County of Santa Clara to assume control of Santa Clara Family Health Plan. This is the result of successful advocacy efforts by Government Affairs staff, contracted state lobbyists at Clear Advocacy, and our partners at other local Medi-Cal MCPs and Local Health Plans of California (LHPC). However, it is anticipated that the author, State Assemblymember Patrick Ahrens, may revisit this proposal next year.

Finally, Assembly Bill 2194 by State Assemblymember Avelino Valencia, which would implement staggered terms on the CalOptima Health Board of Directors and require an external audit of CalOptima Health's governance policies, is currently on the governor's desk. The governor has until September 30, 2026, to sign or veto any bills passed by the state legislature.

D. CalOptima Health Holds Enhanced Care Management (ECM) Community Stakeholder Meeting

On Friday, September 11, CalOptima Health leadership, along with Director Isabel Becerra and representatives from Chair Vicente Sarmiento's office, met with leaders from the seven organizations that shared feedback regarding ECM during the Board meeting on September 3. The discussion was productive and provided an opportunity to better understand the organizations' perspectives, clarify CalOptima Health's current ECM network approach and capacity, discuss near-future program and reimbursement changes, and identify a potential path forward. As a result, subcontracting with one of the 62 existing ECM providers was identified as an opportunity to enable these interested organizations to support members eligible for ECM. The attendees responded positively to this suggestion. To support this solution, CalOptima Health shared a list of all contracted ECM providers with the group to facilitate their outreach regarding potential subcontracting opportunities.

E. DHCS Medi-Cal Unsatisfactory Immigration Status (UIS) Transition Stakeholder Meeting

On September 22, the Department of Health Care Services (DHCS) convened an ad hoc Stakeholder Advisory Committee meeting solely dedicated to the UIS transition from Medi-Cal managed care to fee-for-service. DHCS' presentation from that meeting can be found at:

<https://www.dhcs.ca.gov/september-22-2026-stakeholder-advisory-committee-meeting-materials/>.

F. Medi-Cal Changes Toolkit Created to Raise Awareness, Encourage Action

This month, CalOptima Health's Communications department released a [Medi-Cal Changes Toolkit](#), including flyers, posters, and social media content, to raise awareness about the Medi-Cal changes that began January 1, 2026, and will continue in 2027 and 2028. The materials direct members to the [Medi-Cal Changes webpage](#) for more details. This page provides information that aligns with DHCS messages. The toolkit enables community stakeholders, providers and health networks to easily share information with their communities and urge action so members don't lose their Medi-Cal.

G. Inaugural Senior Health and Wellness Event Welcomes Hundreds of OneCare Members

CalOptima Health held its first annual OneCare Wellness & Resource Fair on September 19, bringing together nearly 400 participants for a day focused on health, connection and community support. Seniors enjoyed breakfast and lunch, participated in engaging presentations, and benefited from on-site vaccinations and dental, medical and vision screenings. Eight internal departments provided resources

and support, while 13 community-based organizations shared information and connected members with additional services. Services included:

- Mercy Health provided 29 flu, 19 COVID-19 and five shingles vaccines
- Central City Community Health Center Dental Mobile Unit conducted 23 dental screenings and provided dental education to 72 attendees
- Serve the People Community Health Center's Vision Mobile Unit conducted 11 vision screenings, provided 11 pairs of glasses, and scheduled three vision follow-ups and two vision exams
- Serve the People Community Health Center's Medical Mobil Unit conducted 20 medical screenings
- Pacific Health and Wellness, in partnership with CalOptima Health's medical management team, completed 10 Health Risk Assessments, 79 blood pressure screenings, and 67 A1C screenings, resulting in 22 care gaps being closed
- SSA completed one CalFresh and four Medi-Cal applications
- Community Action Partnership OC distributed 1,075 pounds of eggs, 1,604 pounds of onions and 630 pounds of tortillas. The organization also enrolled 56 attendees in the Commodities Supplemental Food Program (CSFP) and distributed 22 food boxes to previously enrolled CSFP members.
- CalOptima Health's Pharmacy department conducted two medication reviews
- CalOptima Health distributed 4,200 adult diapers and one pallet of wipes. An insulated cooler cart was also given to each participant

H. Leadership Development Institute (LDI) Focuses on Priority Initiatives

On September 14 and 15, CalOptima Health leaders gathered for LDI to address two major initiatives: response to Medi-Cal changes stemming from H.R. 1 and state budget shortfalls and the launch of CalOptima Health Covered. On the first day of LDI, Board Chair Vicente Sarmiento and Vice Chair Maura Byron joined the group to talk about their background and commitment to the member experience as well as to discuss the CEO search. Later that day, the group reviewed the goals and activities of the H.R. 1 workgroups convened to address member, provider and community needs. On the second day, key members of the CalOptima Health Covered product team led the group in addressing common scenarios that members will encounter as they enroll in and use our new Covered California plan. The goal is a smooth journey toward a January 1, 2027, launch.

I. Press Releases and Media Coverage Highlight Innovative Grant Program

On August 28, CalOptima Health distributed a press release about our first-of-its-kind \$5.2 million City Health Improvement Grants for cities to use to improve health, wellness and quality of life for our members. As a result of the media outreach, we received the following coverage:

- [Orange County Register](#)
- [My News LA](#)
- [New Santa Ana](#)



Fast Facts

October 2026

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

Membership Data* (as of August 31, 2026)

Total CalOptima Health Membership	Program	Members
794,688 Prior month: 801,483	Medi-Cal	774,961
	OneCare (HMO D-SNP)	19,146
	Program of All-Inclusive Care for the Elderly (PACE)	581

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

Key Financial Indicators (for the month ended August 31, 2026)

	Dashboard	YTD Actual	Actual vs. Budget (\$)	Actual vs. Budget (%)
Operating Income/(Loss)	●	(\$8.4M)	\$16.9M	(67.0%)
Non-Operating Income/(Loss)	●	\$19.1M	\$2.8M	17.3%
Covered California Start-up Expenses	●	(\$1.1M)	\$1.5M	58.6%
Bottom Line (Change in Net Assets)	●	\$9.7M	\$21.3M	184.2%
<i>Medical Loss Ratio (MLR)</i> (Percent of every dollar spent on member care)	●	95.5%	---	(1.4%)
<i>Administrative Loss Ratio (ALR)</i> (Percent of every dollar spent on overhead costs)	●	5.7%	---	1.1%

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

Reserve Summary (as of August 31, 2026)

	Amount (in millions)
Board Designated Reserves*	\$1,643.3
Statutory Designated Reserves	\$141.8
Capital Assets (Net of depreciation)	\$125.8
Unspent Balance of Allocated Resources	\$310.3
Unspent Balance of Board Approved Provider Rate Increase	
Increase from 7/1/24 – 12/31/26	\$70.2
Increase from 7/1/26 – 12/31/28	\$401.0
Unallocated Resources*	\$432.4
Total Net Assets	\$3,124.8

* Total Designated Reserves and Unallocated Resources can support about 178 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

October 2026

Personnel Summary (as of September 6, 2026, pay period)

	Filled	Open	Vacancy Administrative	Vacancy Medical	Vacancy % Combined
Staff	1,358	73.75	41	32.75	5.15%
Supervisor	86	2	1	1	2.27%
Manager	116	10	8	2	7.94%
Director	88	1	1	--	1.12%
Executive	21	1	--	1	4.55%
Total FTE Count	1,669	87.75	51	36.75	5.00%

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

Provider Network Data (as of September 21, 2026)

	Number of Providers
Primary Care Providers	1,262
Specialists	8,707
Pharmacies	498
Acute and Rehab Hospitals	46
Community Health Centers	73
Long-Term Care Facilities	254

Treatment Authorizations (as of July 31, 2026)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	43.76 hours
Prior Authorization – Urgent	72 hours	5.97 hours
Prior Authorization – Routine	5 days	1.19 days

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

Member Demographics (as of August 31, 2026)

Member Age		Language Preference		Medi-Cal Aid Category	
0 to 5	8%	English	57%	Expansion	37%
6 to 18	22%	Spanish	28%	Temporary Assistance for Needy Families	35%
19 to 44	33%	Vietnamese	10%	Seniors	13%
45 to 64	20%	Korean	1%	Optional Targeted Low-Income Children	8%
65+	17%	Other	1%	People With Disabilities	6%
		Farsi	1%	Other	<1%
		Chinese	1%	Long-Term Care	<1%
		Arabic	<1%		
		Russian	<1%		

CalOptima Health, A Public Agency

**REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS**

September 3, 2026

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on September 3, 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 Vicente Sarmiento called the meeting to order at 2:03 p.m., and Director Brian Helleland 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 (arrived at 2:05 p.m.); Catherine Green; Brian Helleland; and Janet Nguyen

Director Norma Garcia Guillen participated remotely under "Just Cause" allowances due to medical necessity, using her second of two uses for Calendar Year 2026, pursuant to Government Code section 54953.8.3(c)(3))

Director Veronica Kelley (non-voting) participated remotely under "Just Cause" allowances due to County-related travel, using her first of two uses for Calendar Year 2026, pursuant to Government Code section 54953.8.3(c)(4))

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; 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; Michael Silva Rose, DrPH, LCSW, Chief Health Equity Officer; Tina Knapp, Clerk of the Board; and Ruby Nunez, Executive Assistant

Clerk of the Board Tina Knapp noted for the record that there were no changes to the agenda.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Chief Executive Officer Michael Hunn introduced and welcomed Interim Chief Medical Officer Dr. Richard Lopez. Mr. Hunn's report highlighted recent community events, including the Back-to-School initiative and the Care Traffic Control Center ribbon cutting. He noted ongoing coordination with delegated networks and statewide associations regarding policy changes affecting members and care transitions.

2. Chief Financial Officer Report

Chief Financial Officer Nancy Huang presented a financial update, including preliminary fiscal year 2025-2026 performance, medical and administrative loss ratios, investment income, net position and reserves, and enrollment trends. She previewed a budget revision for January-June 2027 to incorporate confirmed state policy changes and program timing adjustments.

3. Covered California Presentation

Executive Director of Strategic Development Donna Laverdiere provided an implementation update for Covered California, noting progress on regulatory filings, operational readiness for open enrollment beginning November 1, and CalOptima Health's rate position and market participation. Ms. Huang summarized potential impacts of the redesigned Managed Care Organization tax and outlined scenarios and mitigation options pending Centers for Medicare & Medicaid Services and Department of Health Care Services (DHCS) guidance. The Board requested staff to report back on the transition plan from the DHCS pertaining to Unsatisfactory Immigration Status members once it is received.

ADVISORY COMMITTEE UPDATES

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

Dr. John Nishimoto, Provider Advisory Committee Chair, reported on joint Member Advisory Committee/Provider Advisory Committee planning, upcoming agenda items, and leadership transitions. Dr. Nishimoto thanked the Board for its partnership.

PUBLIC COMMENTS

- Becky Nguyen, Vital Access Care Foundation; Virginia Arvizu, Sacred Path Indigenous Wellness Center; Vattana Peong, The Cambodian Family; Angie Rowe, Beyond Blindness; America Bracho, Latino Health Access; Nahla Kayali, Access California Services; and Victor Mendez: provided public comments on CalOptima Health lines of business.
- Stephen Christensen, Olive Crest; Luis Rodriguez, National CORE; Vattana Peong, The Cambodian Family; and Judson Brown, City of Santa Ana: provided public comments on agenda Item 14.
- John Bishop, College Medical Center: provided public comments on agenda Item 15.

The Chair thanked the speakers and noted staff will provide updates on comments made regarding CalOptima Health lines of business to the Board as follow-up meetings occur.

CONSENT CALENDAR

5. Approve Minutes of the June 18, 2026 Special Meeting of the CalOptima Health Board of Directors and August 6, 2026 Regular Meeting of the CalOptima Health Board of Directors
6. Approve Revisions to CalOptima Health Policy CC.1801: Premium Billing and Payment, in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care Filing

7. Approve Actions Related to Covered California Administrative Services Agreements
8. Approve Modifications to CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses
9. Ratify Amendments to CalOptima Health's Primary Agreement and Secondary Agreement with the California Department of Health Care Services
10. Appoint a Persons with Disabilities Representative to the Member Advisory Committee, as well as appoint the Chairs and Vice Chairs of the CalOptima Health Board of Directors' Member Advisory Committee and Provider Advisory Committee
11. Receive and File – Monthly Financial, Compliance, and Government Affairs Reports
 - a. July 2026 Financial Summary
 - b. Compliance Report
 - c. Government Affairs Reports
12. Receive and File – Monthly Community Events and Sponsorship Reports
 - a. CalOptima Health Community Outreach Summary (August & September 2026)
 - b. Sponsorships & Community Participation Including Upcoming Events (August & September 2026)

Action: *On motion of Director Catherine Green, seconded by Vice Chair Maura Byron, by roll call vote the Board of Directors:
Approved the Consent Calendar Agenda Items 5 through 12.*

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

13. Authorize the Chief Executive Officer, or Designee, to Execute a Contract with Orange County United Way for Whatever It Takes Program

Director Norma Garcia Guillen left the meeting during Item 13, at 3:16 p.m.

Action: *On motion of Director Catherine Green, seconded by Director Isabel Becerra, by roll call vote the Board of Directors:*

1. *Authorized the Chief Executive Officer, or designee, to execute a contract with the Orange County United Way for a one-year term, effective October 1, 2026, to continue the Whatever It Takes program.*
2. *Approved the allocation of unallocated Intergovernmental Transfer 8-10 funds in an amount not to exceed \$2.0 million to support the one-year contract with the Orange County United Way.*

AYES: Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Catherine Green; Brian Helleland; and Janet Nguyen

NOES: None
ABSENT: Norma Garcia Guillen
ABSTENTIONS: None
RECUSALS: None

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

Public comments were heard from nonprofit and municipal individuals expressing appreciation and describing planned impacts as noted under the Public Comments section above. Director Isabel Becerra recused from participation due to organizational affiliations.

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

- 1. Approved CalOptima Health staff recommendations to administer grant agreements and award payments totaling \$8.0 million for grant recipients (listed in Attachment 1) related to the Housing and Homelessness Incentive Program.*
- 2. Approved the reallocation of \$3.1 million in unspent funds from Priority 4: Systems Change to Priority 3: Partnerships and capacity to support referrals (capital projects) to be distributed in Housing and Homelessness Incentive Program Notice of Funding Opportunity Round 7.*
- 3. Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.*

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

15. Approve Actions Related to Hospital Quality Assurance Fee Managed Care Pass-through Payment Advancement to College Hospital Costa Mesa

The Board heard one public comment on this item as noted under the Public Comments section above. The Board expressed appreciation for the efforts and willingness of all that are involved with this effort to foster this relationship.

Action: *On motion of Director Blair Contratto, seconded by Director Catherine Green, by roll call vote the Board of Directors:*

- 1. Authorized a one-time Hospital Quality Assurance Fee managed care pass-through payment advancement of \$15.0 million from existing reserves to College Hospital Costa Mesa prior to the receipt of funds from the California Department of Health Care Services for the Calendar Year 2025 Hospital Quality Assurance Fee Program.*
- 2. Authorized the Chief Executive Officer, or designee, to execute a Payment Advancement Agreement with College Hospital Costa Mesa to provide a payment advancement related to the Calendar Year 2025 Hospital Quality Assurance Fee,*

and included secured payment recoupment terms, other appropriate remedies, and recourse protections effective on or after September 3, 2026.

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

16. Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2027

Action: *On motion of Director Blair Contratto, seconded by Vice Chair Maura Byron, by roll call vote the Board of Directors:*

- 1. Authorized the Chief Executive Officer to enter into contracts and/or contract amendments with existing vendors to provide group health insurance for CalOptima Health employees and eligible retirees (and their dependents) for Calendar Year (CY) 2027, which includes the following updates:*
 - a. Medical: Renew the current Blue Shield of California (Blue Shield) Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and PPO Savings High Deductible Health Plan (HDHP) plans; Kaiser Permanente (Kaiser) HMO and Kaiser Senior Advantage health plans; and AmWins Retiree Medicare Supplement Plan.*
 - b. Dental: Continue with the Delta Dental plans that are currently in a rate guarantee through December 31, 2027.*
 - c. Vision: Renew the current VSP vision plans with a rate guarantee through December 31, 2029.*
 - d. Basic life, accidental death, and dismemberment (ADD), short-term disability (STD), and long-term disability (LTD) insurance: Renew current New York Life basic life/ADD, accident, critical illness, STD, and LTD insurance. Accept the enhanced Voluntary Life Guaranteed Issue (GI) amount for employees increasing from \$100,000 to \$150,000 and for spouses increasing from \$30,000 to \$50,000, and an increase to the employee-paid life insurance coverage buy up amounts to provide a total coverage level of twice the employer-paid coverage level.*
 - e. Employee assistance program (EAP): Renew the current Aetna Resources for Living and Counseling Services EAP, which are in a rate guarantee through December 31, 2028. Continue the current Registered Dietician consultations by Taylor Rickrode.*
 - f. Wellness program: Continue the current program with no change to proposed activities.*
 - g. Flexible spending accounts (FSA): Renew the current Wex FSA plan with no change in plan design.*
 - h. COBRA administration: Renew the current Wex plan with no changes.*
 - i. Direct Bill administration: Accept direct bill services through Wex, effective January 1, 2027, to streamline billing services, as well as additional payment*

- options (via ACH) for employees on a leave of absence, as well as for retirees. The administrative cost is \$4.95 per member per month or \$2,079 annually.*
- j. Parental leave program: Renew the contract with Parento through November 2027 for the parental leave program benefit.*
 - k. Pet insurance: Renew the contract with Pet Benefit Solutions for the voluntary pet insurance benefit.*
 - l. No changes to all other plan options and benefit levels other than state and carrier-mandated changes, as well as those mandated by the Internal Revenue Service for the Health Savings Account (HSA) Qualified HDHP and the Dependent Care FSA.*
 - m. As a result of the changes to the CY 2027 benefit renewal, an annual increase in employer contributions for active employee and retiree health plans of 6.5% or approximately \$2,566,540 for CY 2027. The increase is substantially driven by the Blue Shield medical plans due to high utilization and the medical loss ratio.*
 - n. A continuation of employer contributions for CY 2027 in an estimated amount of \$503,100 (included in the estimated cost outlined in “m”) to fund the HSAs monthly for employees anticipated to enroll in the Blue Shield HDHP PPO.*
- 2. Authorize the receipt and expenditures for CalOptima Health staff wellness programs of \$75,000 in funding from Blue Shield for CY 2027.*

AYES: Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Isabel Becerra; Blair Contratto; Catherine Green; Brian Helleland; and Janet Nguyen

NOES: None

ABSENT: Norma Garcia Guillen

ABSTENTIONS: None

RECUSALS: None

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Sarmiento announced that the Board has formed a General Legal Counsel Services Ad Hoc Committee to take a closer look at how CalOptima Health’s general legal services are currently structured and where updates or improvements may be warranted. As part of its work, the committee will consider whether it makes sense to open a solicitation for general legal services. The Committee will look at the pros and cons of doing so and share a recommendation with the Board of Directors. If the committee decides a solicitation should occur, they will oversee and guide that process as well. The individuals assigned to this committee are Director Cathy Green, who will Chair the committee, Director Norma Garcia Guillen, and Director Janet Nguyen. Once the committee completes its review, it will return to the Board with recommendations for next steps.

Vice Chair Byron highlighted the upcoming Family Support Network Pathways TLC Conference on September 26 at Reimagine OC and encouraged community participation. Director Becerra expressed appreciation for partnerships supporting access during forthcoming policy changes. Director Veronica Kelley noted September is National Recovery Month and National Suicide Prevention Awareness Month.

ADJOURNMENT

Hearing no further business, Chair Sarmiento adjourned the meeting at 3:44 p.m.

Tina Knapp
Clerk of the Board

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

May 28, 2026

A Regular Meeting of the CalOptima Health Board of Directors' (Board) Finance and Audit Committee (FAC) was held on May 28, 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 under Past Meeting Materials.

Chair Isabel Becerra called the meeting to order at 3:05 p.m., and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Quorum was declared and present as follows:

Members Present: Isabel Becerra, Chair, Blair Contratto, Brian Helleland
(All FAC members participated in person, except Isabel Becerra, Chair, who participated remotely under Traditional Brown Act Rules.)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Nancy Huang, Chief Financial Officer; John Tanner, Chief Compliance Officer; Steve Eckberg, Chief Human Resource Officer; Eric Rustad, Executive Director, Finance; James Steele, Senior Director, Information Security; Aparna Venkateswaran, Principal, Baker Tilly Stelian Damu, Principal, Baker Tilly, Ashley Merda, Business Assurance Senior Manager, Baker Tilly; Aaron Gates, Principal and Consulting Actuary, Milliman, Tyler Edwards, Associate Actuary, Milliman; Sharon Dwiers, Clerk of the Board; and Pamela Reichardt, Executive Assistant

Executive Assistant Pamela Reichardt noted for the record that staff reordered Agenda Items 9 & 10 to be heard ahead of the Report Items.

MANAGEMENT REPORTS

1. Chief Financial Officer (CFO) Report

Nancy Huang, CFO, provided an update on the business insurance renewal for the 2026-2027 policy year. The Board authorized the Chief Executive Officer (CEO) to approve future business insurance policies. There were no major changes and no new coverage. Staff is required to report back to the Board after obtaining the business insurance policy. The total annual premium is approximately \$4.2 million, representing a 3.3% increase over last year's policy. The dollar increase is approximately \$135,000 in annual cost, driven by higher claim exposure in (i) managed care and (ii) the Program of All-inclusive Care for the Elderly (PACE) line of business, which includes medical malpractice services coverage and workers' compensation, which increased by \$40,000, associated with higher payroll growth. Staff has included sufficient funding for this upcoming business insurance policy renewal. This renewal increase is lower than the market average and is in line with the prior-year inspection.

Ms. Huang reported on key measures from the quarterly report. Ms. Huang provided clarification regarding the Shared Risk Pool ("SRP") structure and the handling of surplus and deficits. She reported that for the Medi-Cal line of business, the split is 60/40; for the health networks, any surplus or deficit will be allocated 60% to the SRP results, with CalOptima Health covering the remaining 40%. If there is an SRP surplus and a regular payout, it will occur twice a year. If there is an SRP deficit, CalOptima Health carries it into the next year, so the results will be calculated using the cumulative deficit, and the deficit will be deducted before paying out any current-year surplus. Ms. Huang reported that there is a true-up on a cumulative basis. For the OneCare line of business, the split is 50/50, the risk arrangement is 50% health network and 50% CalOptima Health. There is a \$ 5-per-member-per-month stop-loss protection at the health network level, which limits the maximum carried into the future year, and any deficit above that level will be absorbed by costs. Going forward, staff will provide the current SRP policy and add notes to the SRP Performance.

2. Cybersecurity Update

James Steele, Senior Director, Information Security, presented an update on CalOptima Health's cybersecurity practices and provided relevant cybersecurity news. Mr. Steele informed the Committee that staff has begun reviewing third-party oversight and disclosure exceptions and will ensure that CalOptima Health adopts and aligns itself with these processes.

Mr. Steele also reported on the quarterly cybersecurity metrics.

In response to a question from the FAC, Mr. Steele reported that during the routine penetration test performed by an independent third party, they identified two repeat findings. Staff has fixed two findings as follows: (i) one regarding a change request, and (ii) staff is currently working with Microsoft to resolve the findings for the other, which should be resolved within a week. Mr. Steele will report on these in detail in closed session due to the sensitivity of the findings at the Board Meeting.

Mr. Steel reported on business email compromises, in which emails are sent with urgency and often include a link to click. Mr. Steele also reported on the effectiveness of the four-minute, monthly employee security training courses in protecting CalOptima Health.

3. Compliance Report

John Tanner, Chief Compliance Officer, reported on the regulatory audits, primarily the annual Medi-Cal regulatory audit conducted by the Department of Health Care Services (DHCS). Mr. Tanner reported as follows:

- The DMHC audit covers utilization management, grievance and appeals, fraud, waste, and abuse.
- The DMHC audit started in February, and the exit conference was held at the end of February.
- DMHC identified five findings, and staff received communication regarding the findings.
- Staff expects a draft report from DMHC later in the year, to be included in next year's audit.
- Internal remediation of findings is underway, and staff observations are incorporated as audit preparation continues.
- Ongoing collaboration with internal business areas for necessary remediations.
- The Medicare line of business audit remains active, despite representing a small percentage of membership.
- The Centers for Medicare & Medicaid Services (CMS) is focusing on Risk Adjustment Data Validation (RADV) audits. CalOptima has had a few, random CMS audits recently. CMS

determined there was approximately \$74,000 in overpayments. CalOptima Health submitted an appeal to CMS for a portion of the overpayment as calculated by CMS.

- The CMS 2015 RADV payment audit found \$105,000 in overpayments.
- Staff is awaiting results for the payment year CMS 2019 RADV audit.

The FAC requested that dollar amounts relative to total payments from Medicare be provided in the future.

Mr. Tanner provided a brief overview regarding audit readiness in general, timeframes and the issuance of final reports with corrective action plans. He stated that when findings are identified, there are opportunities to address them and take the necessary steps to ensure compliance. Staff is well underway in resolving the issues by the time the audit is received so CalOptima Health remains in compliance. Mr. Tanner further explained that the Compliance Department conducts audit readiness work in advance of the audit, so that even if it is an observation, the business area is aware of it and can take action as needed.

Mr. Tanner provided additional clarification on the CMS Medicare Program Audit, noting that CalOptima Health falls in a lower tier with approximately 17,000 OneCare members due to lower enrollment volume.

Michael Hunn, CEO, provided an overview of third-party data validation audits and indicated that CalOptima Health maintains a high level of audit readiness. He stated that the organization consistently undergoes external reviews as part of standard administrative and compliance requirements and noted that the associated costs include vendor fees and internal staff resources across multiple departments needed to support data collection, coordination, and workflow requirements.

4. Treasurer's Report

Ms. Huang presented first-quarter results (January-March 2026). CalOptima Health's portfolio totaled \$3.8 billion: \$2.1 billion in short-term operating accounts and \$1.7 billion in Board-designated reserve accounts. The portfolio complied with Board Policy GA.3001 and Government Code § 53600. Net fund return after fees was 0.59%, down from 1.1% last quarter, primarily due to market volatility and bond performance. The trailing-year net return was 4.29%, exceeding the benchmark. The Investment Advisory Committee supports a one-year contract extension for both investment managers and advisory services, with contracts recommended to extend to September 30, 2027. Staff will work with Meketa for procurement and review of services.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

5. Minutes

- a. Approve the minutes of the February 19, 2026, Regular Meeting of the CalOptima Health Board of Directors Finance and Audit Committee
- b. Receive and File Minutes of the January 26, 2026, Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

Action: *On motion of Director Helleland, seconded by Director Contratto, the Finance and Audit committee approved the Consent Calendar as presented.*

AYES:	Isabell Becerra, Chair; Blair Contratto; and Brian Helleland
ABSENT:	None
ABSTENTIONS:	None
RECUSALS:	None

INFORMATION ITEMS

9. Baker Tilly Financial Audit Planning

Ms. Huang introduced CalOptima Health's financial auditors from Baker Tilly, who presented on the financial audit for the fiscal year ending June 30, 2026.

Baker Tilly Principal, Stelian Damu announced his transition to partner due to mandatory rotation rules. Baker Tilly serves as CalOptima Health's external auditor, assisting with the drafting of financial statements and the collection of federal single audit data. The audit is risk-based, focusing on Medi-Cal claims liability and related processes. Auditors test internal controls, validate management's projections with input from an outside actuary, and review prior year assessments. Findings will be communicated to the FAC as the audit progresses.

Mr. Damu reviewed capitation revenue, receivables, and revenue recognition. He noted that Baker Tilly independently validates CalOptima Health's finance team estimates, investigates discrepancies, and confirms subsequent collections. Baker Tilly also assesses corridor liabilities and receivables as significant exposures, with inputs tested to ensure accuracy and prudent development.

Ashley Merda, Business Assurance Senior Manager, explained that Baker Tilly's responsibility is to reasonably assure that statements are free of misstatements and to notify the FAC if fraud is detected. Audit results for the fiscal year ending June 30, 2026, will be presented at the September 17, 2026, FAC meeting. Two new accounting standards will impact financial statement disclosures next year: one requires more detailed explanations of revenue changes, and the other mandates expanded footnote disclosures of capital assets. CalOptima Health and Baker Tilly will ensure these changes are properly implemented.

In response to a question from the FAC, Ms. Huang indicated that these are routine audits and that staff have been working with Baker Tilly for a long time, so no major changes are anticipated. However, the additional requirement on the Governmental Accounting Standards Board summary report will enhance key components of the financial reporting model to improve usefulness for decision making and accountability and address related application issues. Furthermore, it will require more disclosure for capital assets, and the calculation will be more extensive.

10. CalOptima Health Rebasing Process and Result Overview

Eric Rustad, Executive Director of Finance, presented an update on the Medi-Cal Health Network Capitation Rebasing Project. The rebasing process involves recalibrating base capitation rates to align with forecasted healthcare costs for both medical and non-medical services. Mr. Rustad stated that actuarial partners, Milliman, assisted with data analysis covering April 2022 to March 2025, repricing encounter data to current fee schedules and factoring in prospective changes. The rebasing this cycle uses a single-year midpoint due to enrollment uncertainty, with cost trends and acuity being assessed annually. Steps include data reconciliation, applying fee schedule updates, evaluating unpaid liabilities, reinsurance adjustments, and summarizing results for internal review. Mr. Rustad reported that there were no changes to the age categories during this rebasing cycle; however, there was a change in the age-gender groupings. This is new for CalOptima Health's downstream delegated capitation rates and aligns with the DHCS

methodology. The risk assessment with age-gender grouping change in health network rates was reevaluated after this revision, as changes to the age and gender grouping have a real impact on relative risk.

Mr. Rustad reported on the key points of the methodology. The data from April 1, 2024, through March 2025, was used to forecast fiscal years 2026 and 2027. The data period was chosen because it represented the most recent complete full year of data and was considered fully credible. Mr. Rustad also reported on contractual changes and the proposed rate changes.

DISCUSSION ITEMS

6. Recommend that the Board of Directors Approve the CalOptima Health Fiscal Year 2026-27 Operating Budget:

Action: On motion of Director Contratto, seconded by Director Helleland, the committee recommended that the Board of Directors Approve the CalOptima Health Fiscal Year 2026-27 Operating Budget and Non-Operating Items and authorize expenditures and appropriate funds for the items in Attachment A: Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items and Attachment B: Administrative Budget Details.

Approve the CalOptima Health Fiscal Year 2026-27 Covered California Budget, allocate up to \$7.7 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorize expenditures and appropriate funds for the items in Attachment B1: Covered California Start-up Administrative Budget Details.

Approve the CalOptima Health Fiscal Year 2026-27 Digital Transformation Budget and authorize expenditures and appropriate funds for the items in Attachment B2: Digital Transformation Administrative Budget Details.

Direct the Chief Executive Officer, or Designee, to make a commitment of up to \$429.6 million from existing reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County for a 2.5-year period (in other words, i.e., July 1, 2026, through December 31, 2028).

AYES:	Isabell Becerra, Chair; Blair Contratto; and Brian Helleland
ABSENT:	None
ABSTENTIONS:	None
RECUSALS:	None

Ms. Huang presented CalOptima Health's operating budget proposal for fiscal year 2026-27. She noted that if there are any major policy or program changes, including state and federal policies, after the initial budget is presented to the Board, staff will bring back additional recommendations or a revised budget package to a future meeting for consideration.

Mr. Hunn commented that the state is undertaking its May budget revision and that there will be changes at the federal level regarding the undocumented immigration-status (UIS) population. He noted that the

budget is anticipated to be signed by the governor on June 15, 2026. Legislative action will take place through September, so budget adjustments will be made accordingly and brought back to the FAC and then to the Board.

Ms. Huang further reported that the budget was developed based on historical trends and did not include the potential UIS member carve-out proposed in the state's May revised budget or the January 2027 carve-out. She stated that the budget incorporates funding for planned provider rate increases, including hospital outpatient care and physician specialists, and reflects the most recent rebasing results and adjustments to Medi-Cal delegated entities, capitation reimbursement, and outward-bound kick reinsurance. Discussions on Proposition 35 and CMS approval of the Managed Care Organization tax are pending. Budget considerations include anticipated impacts from HR 1 provisions on Medicaid enrollment, adult undocumented member freeze, changes for seniors and persons with disabilities, community engagement requirements, and Affordable Care Act expansion member redeterminations. The new Covered California line of business launches in January 2027 and includes six months of routine expenses and start-up costs funded by CalOptima Health's reserves. The budget covers Medi-Cal, OneCare, PACE, Medicare Shared Services Program, and Covered California, with provider rate increases and digital transformation strategies handled below the line starting January 2027.

Ms. Huang presented an overview of the governor's May revised budget for fiscal year 2027, which proposes a balanced budget through June 2028. Key points include an 11.5% (\$22.3 billion) increase to the Medi-Cal budget, with statewide enrollment expected to decrease by 3.75% to 13.9 million members. The proposal calls for transitioning UIS members from managed care to fee-for-service as of January 1, 2027, impacting over 2 million members statewide, including approximately 130,000 CalOptima Health members. Additionally, the May revised budget reinstates lower asset limits for long-term care, affecting an estimated 25,000 to 30,000 members, primarily seniors.

Ms. Huang presented CalOptima Health's capital budget proposal for fiscal year 2026-27, totaling \$52.9 million. Of this, 65% is allocated to technology and \$34.2 million to building and office improvements. The \$18.6 million budget request covers routine capital items, with office improvements totaling up to \$7 million from last year, due to elevator replacements (\$5 million) and the build-out of vacant space (\$3.75 million). Approximately \$9 million is allocated to digital transformation projects, including Board-approved improvements to the data exchange platform and automation processes.

Ms. Huang presented the fiscal year 2026-27 total proposed budget of \$4.86 billion dollars. For medical and administrative expenses, the proposed operating expense budget is \$4.82 billion. Based on current assumptions, CalOptima Health estimates an operating surplus of \$41.4 million dollars (less than 1%). Projecting a balanced budget with a small operating surplus.

7. Recommend that the Board of Directors Approve the CalOptima Health Fiscal Year 2026-27 Routine Capital and Digital Transformation Year Five Capital Budget

Action: *On motion of Director Helle/and, seconded by Director Contratto, the committee recommended that the Board of Directors approve the Ca/Optima Health Fiscal Year 2026-27 Routine Capital Budget and authorize expenditures and appropriate funds for the items in Attachment A: Fiscal Year 2026-27 Routine Capital Budget by Project.*

***Approve the CalOptima Health Fiscal Year 2026-27 Digital Transformation Year Five Capital Budget to complete ongoing and new projects and authorize expenditures and appropriate funds for the items in Attachment A1: Fiscal Year 2026-27 Digital Transformation Year Five Capital Budget by Project.
(Motion carried 3-0-0)***

AYES: Isabell Becerra, Chair; Blair Contratto; and Brian Helleland
ABSENT: None
ABSTENTIONS: None
RECUSALS: None

8. Recommend that the Board of Directors approve modifications to CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage

***Action: On motion of Director Contratto, seconded by Director Helleland, the committee recommended that the Board of Directors approve modifications to CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage effective July 1, 2026
(Motion carried 3-0-0)***

AYES: Isabell Becerra, Chair; Blair Contratto; and Brian Helleland
ABSENT: None
ABSTENTIONS: None
RECUSALS: None

INFORMATION ITEMS

The following items were accepted as presented.

11. March 2026 Financial Summary

This item was discussed during the CFO's Report.

12. Quarterly Operating and Capital Budget Update

13. Update to Business Insurance Renewal for Policy Year 2026-27

14. CalAIM Program Summary

15. Quarterly Reports to the Finance and Audit Committee

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

COMMITTEE MEMBER COMMENTS

The FAC thanked Sharon Dwiers, Clerk of the Board, for her many years of service and commitment to the agency upon her retirement.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 5:49 p.m.



Pamela Reichardt, Executive Assistant

Approved: September 17, 2026

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

3. Approve Reappointment and Committee Chair Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

Contact

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

Recommended Action

1. Reappoint Rodney Johnson to the Investment Advisory Committee for a two (2)-year term, beginning October 6, 2026, and continuing until October 5, 2028; and
2. Reappoint Rodney Johnson to serve as Chair of the Investment Advisory Committee for a two (2)-year term, beginning October 6, 2026, and continuing until October 5, 2028, or until a successor is appointed.

Background

At a Special Meeting of the CalOptima Health Board of Directors (Board) held on September 10, 1996, the Board authorized the creation of the CalOptima Health Investment Advisory Committee (IAC), established qualifications for IAC members, and directed staff to proceed with the recruitment of the volunteer members of the IAC.

When creating the IAC, the Board specified that the IAC would consist of five (5) members, including one (1) member who would automatically serve by virtue of his or her position as CalOptima Health's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima Health on its investment activities.

Discussion

The candidate recommended for reappointment, Rodney Johnson, has consistently provided leadership and service to CalOptima Health through his long-time participation as an IAC member.

Mr. Johnson has served as a member of the IAC since June 6, 2013, and has over 30 years of experience in the field of public finance. He is currently the Treasurer for Los Angeles County Metropolitan Transportation. Mr. Johnson previously worked as the Deputy Treasurer of the Orange County Transportation Authority and has extensive public and private-sector experience, specializing in municipal finance, defined contribution, and defined benefit retirement plans. His responsibilities include all aspects of municipal debt issuance and administration; investment of public funds; and creation, implementation, and management of public policy. Mr. Johnson has a Master of Public Administration degree from California State University, Long Beach and a Bachelor of Arts degree from California State University, Fullerton.

Fiscal Impact

There is no fiscal impact. An individual appointed to the IAC assists CalOptima Health in suggesting updates to and ensuring compliance with CalOptima Health's Board-approved Annual Investment Policy, and monitors the performance of CalOptima Health's investments, investment advisors, and investment managers.

Rationale for Recommendation

The individual recommended for reappointment to CalOptima Health's IAC and reappointment as the IAC Chair has extensive experience that meets or exceeds the specified qualifications for IAC membership.

Concurrence

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

Attachments

None.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026 **Regular Meeting of the CalOptima Health Board of Directors**

Consent Calendar

4. Approve Reappointments to the CalOptima Health Board of Directors' Investment Advisory Committee

Contact

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

Recommended Action

Reappoint the following individuals to the Board of Directors' Investment Advisory Committee for two (2)-year terms beginning October 6, 2026, and continuing until October 5, 2028:

1. Colleen Clark; and
2. David Hutchison.

Background

At a Special Meeting of the CalOptima Health Board of Directors (Board) held on September 10, 1996, the Board authorized the creation of the CalOptima Health Investment Advisory Committee (IAC), established qualifications for IAC members, and directed staff to proceed with the recruitment of the volunteer members of the IAC.

When creating the IAC, the Board specified that the IAC would consist of five (5) members, including one (1) member who would automatically serve by virtue of his or her position as CalOptima Health's Chief Financial Officer (CFO). The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima Health on its investment activities.

Discussion

The candidates recommended for reappointment have proven leadership and expertise in finance and accounting.

Colleen Clark has served as a member of the IAC since October 1, 2020, and has over 27 years of experience and knowledge of public finance, investments, accounting, and government and legislative

processes. Ms. Clark was the Director of Public Finance for the County of Orange and worked as the Deputy Chief Executive Officer and Chief Financial Officer (CFO) for the Orange County Great Park. Ms. Clark served as the CFO at the Transportation Corridor Agency in Irvine and is a retired Certified Public Accountant.

David Hutchison, Chartered Financial Analyst (CFA), has served as a member of the IAC since October 1, 2020, and currently works for Triad Investment Management, where he is a Partner and Portfolio Manager. Mr. Hutchison has over 20 years of investment experience and has previously held positions as President of Hutchison Capital, Investment Strategist for Chamberlain Group, and Senior Equity Analyst for Insight Capital Research & Management. He is a member of both the CFA Institute and the CFA Society Orange County.

Fiscal Impact

There is no fiscal impact. Individuals appointed to the IAC assist CalOptima Health in suggesting updates to and ensuring compliance with CalOptima Health's Board-approved Annual Investment Policy, and monitor the performance of CalOptima Health's investments, investment advisor, and investment managers.

Rationale for Recommendation

The individuals recommended for reappointment to CalOptima Health's IAC have extensive experience that meets or exceeds the specified qualifications for IAC membership.

Concurrence

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

Attachments

None.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Adopt Resolution No. 26-1001-01 Approving Updated CalOptima Health Human Resources Policies

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570

Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Action

Adopt Resolution No. 26-1001-001 approving updated CalOptima Health policies, effective October 1, 2026:

1. CalOptima Health Policy AA.1252: Workforce Engagement and Opportunity;
2. CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention;
3. CalOptima Health Policy GA.8036: Education Reimbursement; and
4. CalOptima Health Policy GA.8050: Confidentiality.

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 the four (4) revised policies for Board approval and a summary of changes for the updated policies below.

AA.1252 Workforce Engagement and Opportunity: This policy describes CalOptima Health's commitment to workforce engagement and opportunity, supporting the organization's health initiatives and strategic goals by driving opportunities for development and advancement for all employees. It emphasizes aligning employee engagement with the mission and values and maintaining channels for communication and feedback within the workforce.

Policy Section	Proposed Change	Rationale	Impact
Title	Change policy title from "Diversity, Equity, and	Title change reflects the revised purpose and scope of this policy to	For clarity and transparency for the policy title to

Policy Section	Proposed Change	Rationale	Impact
	Inclusion” to “Workforce Engagement and Opportunity”.	employee engagement and opportunities.	reflect the revised policy scope.
I. Purpose	Revise “This policy describes CalOptima Health’s Diversity, Equity, and Inclusion (DEI) commitment to support and advance its health equity strategy by building a diverse and inclusive staff while supporting health equity goals that are aimed at reducing bias and improving DEI within the workplace, its Committees, and Governance Bodies” to “This policy describes CalOptima Health’s commitment to Workforce Engagement and Opportunity supporting the organization’s health initiatives and strategic goals by driving opportunities for development and advancement for all Employees. It emphasizes aligning Employee engagement to our mission and values and maintaining channels for communication and feedback within the workforce.”	Policy changes align policy to practice, to the Employee Handbook, and the HR strategic plan. Revisions narrow the scope of policy to Employees and workforce by removing “Committees and Governance Bodies” in the section and throughout policy. Revisions support and meet Covered California contract requirements in Section 1.04.02 Workforce.	Clarifies and aligns the title, purpose, and scope of the policy from DEI to an employee engagement policy focused on communication and shared values.
II.Policy.A.1.	1. Add “compensation” to agency’s ongoing commitment “to attract and retain a workforce of diverse talents”. 2. Remove “DEI” as the goal of the agency’s commitment.	Aligns to revised purpose of the policy.	Clarifies and aligns compensation and recruitment practices to the agency’s commitment to attract and retain talented workforce.
II.Policy.A.2.	Revise “that is reflective of the” community to “that meets the service delivery needs” of the community.	Aligns to the revised purpose of the policy.	Clarifies and aligns employee engagement with meeting the needs of CalOptima

Policy Section	Proposed Change	Rationale	Impact
			Health's community.
II.Policy.A.3.	Revise "Maintain a consistent approach for building a diverse and inclusive staff" to "Support a workforce Open Door approach to communication and feedback with leadership."	Aligns to the revised purpose of the policy. Aligns policy to practice as open door approach is described in the Employee Handbook.	Aligns policy to practice on the open door approach staff have with leadership and Human Resources (HR).
II.Policy.A.4.	1. Revise "DEI" to "health outcomes and cultural humility" training. 2. Remove "at least annually thereafter".	Aligns to revised purpose of the policy and training CalOptima Health Policy AA.1251: Health Outcomes Training Program	Aligns training requirements in Policy AA.1251 to employee engagement.
II.Policy.A.5.	Add subsection: "Establish an Employee Engagement Team for eligible employees to share ideas, strategies, and activities to enhance employee engagement."	Aligns to the revised purpose of the policy and aligns policy to practice as Employee Engagement Team is described in the Employee Handbook.	Aligns policy to practice on scope and purpose of the Employee Engagement Team.
II.Policy.B	Remove section: "Our hiring and recruitment practices shall promote Diversity for both Internal and External Applicants, promotions and reclassifications, and temporary and permanent positions."	Redundant with CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring.	Provides clarity and consistency of the policy to its revised purpose.
II.Policy.B	1. Revise "regularly" to "periodically". 2. Remove "at a minimum" from frequency of the actions described in this section.	Provides CalOptima Health with the discretion to evaluate its staffing and how it meets the needs of the community.	Provides clarity and consistency of the policy to its revised purpose.
II.Policy.B.1.	Revise "reflects" to "meets" and "Diversity of the" population to "needs of our" population.	Provides CalOptima Health with the discretion to evaluate its staffing and how it meets the needs of the community.	Provides clarity and consistency of the policy to its revised purpose.
II.Policy.B.2.	Revise "which groups are inadequately represented in the	Provides CalOptima Health with the	Provides clarity and consistency

Policy Section	Proposed Change	Rationale	Impact
	workforce” to whether specific “functions or departments have staffing gaps”.	discretion to evaluate its staffing and how it meets the needs of the community.	of the policy to its revised purpose.
II.Policy.B.3.	Revise “Whether specific groups are marginalized, disenfranchised or disempowered by our recruitment and hiring practices” to “How Employee engagement supports organizational programs and plans for serving Members.”	Provides CalOptima Health with the discretion to evaluate its staffing and how it meets the needs of the community.	Provides clarity and consistency of the policy to its revised purpose.
II.Policy.D	Remove section: “CalOptima Health shall ensure that our hiring and recruitment policies explicitly address how CalOptima Health promotes Diversity for our staff, Leadership, and Committees.”	Redundant with Policy GA.8060: Recruitment, Selection, and Hiring.	Provides clarity and consistency of the policy to its revised purpose.
II.Policy.C	Revise “CalOptima Health shall conduct an analysis at least annually to identify opportunities to improve Diversity, Equity, Inclusion and/or Cultural Humility for staff, Leadership, Governance Bodies, and Committees” to “CalOptima Health may conduct a range of surveys, interviews, and questionnaires to identify workforce engagement and development opportunities such as 360 feedback review, training needs assessments, benefit and wellness plan surveys, exit interviews, focus groups, and Employee engagement surveys.”	Provides CalOptima Health with the tools and methods to evaluate its workforce and how it meets the needs of the community.	Provides clarity and consistency of the policy to its revised purpose.
II.Policy.C.1.	Revise “CalOptima Health shall implement interventions to address identified opportunities to improve Diversity, Equity, Inclusion and	Provides CalOptima Health with the tools and methods to evaluate its workforce and how it meets the	Aligns to revised purpose of the policy and aligns policy to practice in conducting

Policy Section	Proposed Change	Rationale	Impact
	Cultural Humility for at least one of the groups (staff, Leadership, Committees or Governance Bodies)” to “This data shall be used to implement interventions, address identified gaps and opportunities and eliminate barriers to workforce engagement and development.”	needs of the community.	various workforce surveys and assessments.
III.Procedure.A.1	Under Section A, Hiring and Recruiting, remove header “Staff and Leadership, adds to section “compensation”, revises “promotes Diversity” to “considers opportunities for career development and future leadership needs”. Add reference to policy GA.8057 Compensation Program.	Aligns compensation and recruitment process with talent management and engagement strategy.	Aligns to revised Purpose of the policy and aligns to the HR strategic plan.
III.Procedure.A.1.a	Add section: “Human Resources may periodically select posted vacancies for greater internal visibility by spotlighting them to all employees as opportunities for advancement”.	Aligns policy to practice of internally promoting “hot jobs”.	Aligns policy to practice generating internal interest in posted recruitments.
III.Procedure.A.1.b	Replace “To promote Diversity and Inclusion, the organization” with “CalOptima Health” and describes what it will do.	Removes reference to DEI and identifies the agency’s approach to job descriptions.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.A.1.b.ii	Remove “Salary range for each position” and replace it with “Fair Labor Standards Act (FLSA) Status”.	Aligns policy to practice of writing job descriptions.	For transparency and consistency in job description standards.
III.Procedure.A.1.b.iii	Add “Work Environment description”.	Aligns policy to practice of writing job descriptions.	For transparency and consistency in job description standards.
III.Procedure.A.1.b.iv	Add “Physical Demands including mobility”.	Aligns policy to practice of writing job descriptions.	For transparency and consistency in job description standards.

Policy Section	Proposed Change	Rationale	Impact
III.Procedure.A.1.b.v	Revise “Reduce the requirements of each position to” to “Only” the must-have qualifications “for each position”.	Aligns policy to practice of writing job descriptions.	For transparency and consistency in job description standards.
III.Procedure.A.1.i (original)	Remove “Job Announcements to include the following” section.	Redundant with Policy GA.8060 which describes job announcements.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.A.2 (original)	Remove “Committee Membership” section.	Aligns to revised purpose of the policy where committees are out of scope.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.A.3 (original)	Remove “Governance Body” section.	Aligns to revised purpose of the policy where governing bodies are out of scope.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.B.1	Remove “Recruitment and Selection” section.	Redundant with Policy GA.8060 which describes recruitment and selection in more detail.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.A.2	Revise the following: 1. Replace “assess the performance” with “maintain a dashboard;” and 2. Add measures to the following list: “a. Internal Fill Rate (%); b. Organizational Demographics; c. Position Vacancy Rate (%); and d. Turnover Rate (%).”	Aligns policy to practice in creating the monthly HR Fast Facts report.	Provides consistency and transparency in the reporting of workforce data.
III.Procedure.B.1	Add section: “Open Door Approach: 1. CalOptima Health encourages employees to ask questions and share their opinions, ideas, and feedback regarding decisions	Aligns with the revised purpose of the policy and aligns policy to practice. The Open Door approach is	Provides clarity and consistency with the Open Door approach to communication and engagement.

Policy Section	Proposed Change	Rationale	Impact
	affecting them or their job responsibilities and to improve operations with their department leaders, Human Resources, or CEO. a. Employees may engage in the Open Door Approach using any of the available communication channels including email, telephone, Teams, and in-person. b. CalOptima Health will keep inquiries confidential to the extent possible based on a review of the business and legal obligations. c. Retaliation against any employee for raising a concern or participating in an inquiry is prohibited under GA.8027 Harassment, Discrimination, and Retaliation Prevention policy.”	described in the Employee Handbook.	
III.Procedure.C	Remove section: “To promote Culturally and Linguistically Appropriate Services (CLAS) and DEI, the organization performs the following tasks”.	Aligns to revised purpose of the policy.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.C	Add “and Development” to section header.	Aligns to revised purpose of the policy.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.C.1	1. Add “in interviews”, “possibility of unconscious biases”, and “impacting hiring decisions”; and 2. Remove “of biases and discrimination during the interview phase”.	Drives growth and development opportunities by training recruiters and hiring managers on how to conduct interviews.	Provides clarity and consistency of the policy to its revised purpose.

Policy Section	Proposed Change	Rationale	Impact
III.Procedure.C.2	Revise “CalOptima Health” to “Human Resources” and adds “the learning management system to host trainings” and revises Policy AA.1251 title.	Aligns to revised purpose of the policy, aligns to Policy AA.1251, and clarifies HR’s role in providing the learning platform.	Provides clarity and transparency in the hosting of training programs.
III.Procedure.C.2.b	Revise “annually” to “biannually” training frequency.	Aligns to revised purpose of the policy, aligns policy to practices, and aligns to Policy AA.1251.	Provides clarity and transparency in the hosting of training programs.
III.Procedure.C.4	Revise “CLAS and DEI” to “health outcomes and our CARES Values”.	Aligns to revised purpose of the policy and Employee Handbook on CARES Values.	Provides clarity and consistency of the policy to its revised purpose.
III.Procedure.C.4.a	Add “Human Resources shall maintain an inventory of required and optional training courses offered in the learning management system (LMS). Courses completed in the LMS are recorded and part of the employees’ training transcript.”	Provides clarity on the maintenance of the training library, learner records and aligns to Covered California contract.	Provides clarity and transparency with training records.
III.Procedure.D	Add section: “Employee Engagement Team 1.CalOptima Health may establish a workgroup of staff and executive leadership to communicate ideas and strategies, and conduct activities to enhance Workforce Engagement and Opportunity. 2.Human Resources will maintain the Employee Engagement Team Charter.”	Aligns to the revised purpose of the policy and aligns policy to practice as Employee Engagement Team is described in the Employee Handbook.	Provides clarity and consistency of the role of the Employee Engagement Team.
V. References. A	Revise policy title “Diversity, Equity and Inclusion” to “Health Outcomes”.	Aligns to the revised title for Policy AA.1251.	For clarity and accuracy with referenced policy.
V. References. B.	Replace CalOptima Health Policy “GA.8030: Background Check” with “GA.8057: Compensation Program”.	Revised for clarity and alignment with new purpose statement.	Provides clarity and accuracy with the referenced policy.

Policy Section	Proposed Change	Rationale	Impact
V. References. C.(original)	Removed reference to “CalOptima Health Policy GA.8022: Performance and Behavior Standards”.	Removed for clarity and alignment with new purpose statement.	Provides clarity and accuracy.
V. References. D	Add reference to “Covered California Contract Attachment 1 Section 1.04.2 Workforce”.	Policy designed to support Covered California contract requirements section.	Provides clarity and accuracy.
V. References. E	Add “And” and “(Supersedes APL 23-025)”.	For accuracy to their program title and All Plan Letter.	Provides clarity and accuracy.
V. References. G	Add “Employee Engagement Team Charter”.	Supports new section on Employee Engagement Team.	Provides clarity and accuracy.
V. References. H	Revise NCQA “Equity Standards” to “Outcomes Accreditation”.	For accuracy to the revised program title.	Provides clarity and accuracy.
IX. Glossary (original)	Remove the terms and definitions for “Committee”, “Cultural Humility”, “Diversity”, “Equity”, “External Applicant”, “Governance Body”, “Inclusion”, Internal Applicant”, and “New Position”.	For clarity and alignment with the revised policy.	Provides clarity and accuracy.
IX. Glossary	Add “CARES Values” and “CalOptima Health’s core values of Collaboration, Accountability, Respect, Excellence, and Stewardship.”	For clarity and alignment with the Employee Handbook.	Provides clarity and accuracy.
IX. Glossary	Add Internal “Fill Rate” and “Percentage of total open positions filled by existing employees.”	For consistency and alignment with HR Fast Facts report.	Provides clarity and accuracy.
IX. Glossary	Add “Organizational Demographics” and “CalOptima Health census data of employee age, gender, and ethnicity categories.”	For consistency and alignment with HR Fast Facts report.	Provides clarity and accuracy.
IX. Glossary	Add “An individual” to definition of Member.	For accuracy of the Glossary term.	Provides clarity and accuracy.
IX. Glossary	Add Position “Vacancy Rate” and “Percentage of open	For consistency and alignment with HR Fast Facts report.	Provides clarity and accuracy.

Policy Section	Proposed Change	Rationale	Impact
	positions as compared to budgeted positions.”		
IX. Glossary	Add “Turnover Rate” and “Number of separated employees as compared to the average number of total employees in a given period.”	For consistency and alignment with HR Fast Facts report.	Provides clarity and accuracy.
IX. Glossary	Add “Workforce Engagement and Opportunity” and “Developing and supporting our Employee’s commitment and connection to the mission, values, members, and one another through purposeful and meaningful work, trusted and valued relationships, and opportunities for professional growth and development.”	For consistency and alignment with the revised policy.	Provides clarity and accuracy.

GA.8027 Harassment, Discrimination, and Retaliation Prevention: This policy outlines CalOptima Health’s zero tolerance for discrimination, harassment, and retaliation and sets forth a procedure for promptly investigating complaints thereof.

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	Add the following categories: 1. “traits historically associated with race such as hair texture and style”; 2. “perceived disability, history of disability”; 3. “survivor or family member of a victim of violence and certain crimes”; and 4. “time off work for mandatory jury duty service, perception that anyone has any of those characteristics, association with anyone that has any of those characteristics”.	Aligns categories to Policy GA.8025: Equal Employment Opportunity.	Provides transparency and accuracy to the list of protected characteristics under this policy.
II.Policy.D	Replace “supervisors, managers, and coworkers” with “Employees at all levels”.	Aligns policy to practice and with Glossary term.	For clarity and accuracy with Glossary term Employee.

Policy Section	Proposed Change	Rationale	Impact
II.Policy.D	Add “to the Human Resources Department”.	For clarity on where leaders are to report issues to and aligns to procedure section.	Provide consistency and transparency in reporting under this policy.
II.Policy.G.2	Add “Leaders and investigators may not promise absolute confidentiality and must disclose information as needed to conduct a fair investigation.”	Aligns policy to practice in the handling of complaints.	Provide consistency and transparency in reporting under this policy.
II.Policy.G.3	Replace “appropriate due process” with “with an opportunity to be heard”.	Aligns policy to practice in the handling of complaints.	Provide consistency and transparency in reporting under this policy.
II.Policy.G.4	Add “in good faith”.	Aligns policy to practice in the handling of complaints.	Provide consistency and transparency in reporting under this policy.
II.Policy.I.2.a.iv	Add “or sharing”, “GIFs”, and “videos”.	Adds examples of unwelcome sexual conduct under policy.	Provides clarity and transparency to prohibited behavior.
II.Policy.I.2.a.v	Add “chat messages” and “memes”.	Adds examples of unwelcome sexual conduct under policy.	Provides clarity and transparency to prohibited behavior.
II.Policy.I.2.a.vi	Add “verbal abuse of a sexual nature”.	Adds examples of unwelcome sexual conduct under policy.	Provides clarity and transparency to prohibited behavior.
II.Policy.I.2.a.viii	Add “Making or threatening retaliatory action after receiving a negative response to a sexual advance”.	Adds examples of unwelcome sexual conduct under policy.	Provides clarity and transparency to prohibited behavior.

Policy Section	Proposed Change	Rationale	Impact
II.Policy.I.2.a.ix	Add “Cyberstalking or repeatedly contacting an Employee online with sexual messages; or”	Adds examples of unwelcome sexual conduct under policy.	Provides clarity and transparency to prohibited behavior.
II.Policy.I.2.a.x	Add “Sending unwanted messages of a sexual nature through social media if the conduct is connected to the workplace or affects the employee's work environment.”	Adds examples of unwelcome sexual conduct under policy.	Provides clarity and transparency to prohibited behavior.
II.Policy.K	Add “Online activities conducted during work hours or for work-related purposes are considered part of the workplace and are subject to the CalOptima Health Harassment, Discrimination, and Retaliation Prevention policy.”	Aligns policy to practice and standards described in Policy GA.8062: Social Media Conduct.	Provides clarity and transparency to prohibited behavior.
II.Policy.M.5	Add “Where the reported behavior does not rise to the level of violating this policy, CalOptima Health may resolve the issue informally, for example, through counseling. If the report contains allegations of conduct that may violate this policy, a formal investigation will be conducted to determine the facts.”	Aligns policy to practice on the evaluation and resolution of complaints under this policy.	Provides transparency and consistency on the handling of complaints under this policy.
II.Policy.M.5	1. Remove “formal” to describe the type of complaint. 2. Replace “may” with “will” to address the handling of the complaint.	Aligns policy to practice on the evaluation and resolution of complaints under this policy.	Provides transparency and consistency on the handling of complaints under this policy.
II.Policy.M.6	Format M.5 into subsections 5 and 6.	Creates subsection on the handling of anonymous complaints.	Provides clarity.
II.Policy.M.7	1. Remove “reporting of the”. 2. Add “and in good faith”.	Aligns policy to practice in the handling of complaints.	Provides transparency and consistency on the handling of complaints

Policy Section	Proposed Change	Rationale	Impact
			under this policy.
II.Policy.N.2	1. Remove “punitive damages” and “Training developed by the CRD can be accessed at the following link”. 2. Add “awarding”.	Aligns policy to practice in the handling of complaints.	Provides transparency and accuracy on the handling of complaints under this policy.
III.Procedure.Human Resources	Capitalize “Creditability” and “Preponderance of the Evidence Standard” as new Glossary terms.	Glossary additions of investigatory terms.	Provides accuracy and consistency of terms used in policy.
III.Procedure.Human Resources	1. Add “review or”. 2. Replace “responding” with “accused” party.	Aligns policy to practice in the handling of complaints.	Provides transparency and accuracy on the handling of complaints under this policy.
IX.Glossary	Add the term “Credibility” defined as “The investigator’s evaluation of whether a person’s statements made in an investigation are believable, can be relied upon, and are supported by evidence.”	Adds investigatory term to Glossary.	Provides accuracy and consistency of terms used in policy.
IX.Glossary	Revise definition of term “Member” by replacing “A beneficiary” with “An individual” enrolled in a CalOptima Health Program.	Correction of Glossary term.	Provides accuracy and consistency of terms used in policy.
IX.Glossary	Add term “Preponderance of the Evidence” defined as “Defined by the California Civil Rights Department as the ‘more likely than not’ standard. It requires the investigator to determine whether it is more likely than not that the alleged conduct did or did not occur.”	Adds investigatory term to Glossary.	Provides accuracy and consistency of terms used in policy.
Attachment A.	Add “Complete all fields to the extent possible, sign, and submit it with any Attachments to Human	Adds user instructions to complete the form and send it to HR at the start of the form.	Provides clarity and consistency on the reporting of

Policy Section	Proposed Change	Rationale	Impact
	Resources Employee Relations at employeeerelations@caloptima.org.”		complaints under this policy.
Attachment A.	Revise and enumerate Question 1 from “WHAT IS THE SPECIFIC SITUATION THAT BROUGHT YOU TO CONTACT HUMAN RESOURCES TODAY? PLEASE INCLUDE INCIDENT AND DATE:” to “1. WHAT IS THE SPECIFIC SITUATION THAT YOU ARE REPORTING FOR REVIEW? PLEASE INCLUDE DATE, TIME AND LOCATION:”	Revises user instructions on how to complete the form section.	Provides clarity and consistency on the reporting of complaints under this policy.
Attachment A.	Revise and enumerate Question 2 from “NAME(S) AND POSITION OF EMPLOYEE(S) CONTRIBUTING OR INVOLVED IN THE REPORTED INCIDENT:” to “2. PROVIDE THE NAMES AND POSITIONS OF EVERYONE INVOLVED IN THE REPORTED INCIDENT AND THEIR RELATIONSHIP TO YOU:”	Revises user instructions on how to complete the form section.	Provides clarity and consistency on the reporting of complaints under this policy.
Attachment A.	Revise and enumerate Question 3 from “GIVE SPECIFIC EXAMPLES OF THEIR BEHAVIOR/ACTIONS? PLEASE INCLUDE DATES, TIMES, AND LOCATION:” to “3. GIVE SPECIFIC EXAMPLES OF THEIR BEHAVIOR AND ANY INFORMATION OR BELIEF AS TO WHAT MOTIVATED ANY OF THESE ACTIONS.”	Revises user instructions on how to complete the form section.	Provides clarity and consistency on the reporting of complaints under this policy.
Attachment A.	Revise and enumerate Question 4 from “IDENTIFY WHO MAY HAVE WITNESSED OR HAVE KNOWLEDGE OF THE INCIDENTS. PLEASE PROVIDE NAME(S) AND POSITIONS. FOR NON-EMPLOYEES INDICATE RELATIONSHIP AND CONTACT INFORMATION IF	Revises user instructions on how to complete the form section.	Provides clarity and consistency on the reporting of complaints under this policy.

Policy Section	Proposed Change	Rationale	Impact
	AVAILABLE.” to “4. IDENTIFY THOSE WHO MAY HAVE WITNESSED OR HAVE KNOWLEDGE OF THE INCIDENTS. PLEASE PROVIDE NAMES, POSITIONS, AND CURRENT RELATIONSHIP, WHERE APPLICABLE.”		
Attachment A.	Revise and enumerate Question 5 from “DO YOU HAVE ANY RELEVANT DOCUMENTS OR OTHER EVIDENCE TO SUPPORT YOUR CLAIM(S)? IF YES, PLEASE LIST THEM HERE AND ATTACH COPIES WITH THIS FORM.” to “5. PROVIDE ANY RELEVANT DOCUMENTS OR OTHER EVIDENCE TO SUPPORT YOUR COMPLAINT. PLEASE LIST THEM HERE AND INCLUDE COPIES WITH THIS FORM SUBMISSION.”	Revises user instructions on how to complete the form section.	Provides clarity and consistency on the reporting of complaints under this policy.
Attachment A.	Revise and enumerate Question 6 from “HAVE YOU REPORTED THIS COMPLAINT TO YOUR DEPARTMENT LEADERSHIP? IF SO, DESCRIBE ANY EFFORTS TO INFORMALLY RESOLVE YOUR COMPLAINT, INCLUDING DATES AND TIMES AND OUTCOMES” to “6. HAVE YOU REPORTED THIS COMPLAINT TO YOUR DEPARTMENT LEADERSHIP? IF SO, DESCRIBE ANY EFFORTS TO INFORMALLY RESOLVE YOUR COMPLAINT, INCLUDING DATES AND TIMES AND OUTCOMES.”	Revises user instructions on how to complete the form section.	Provides clarity and consistency on the reporting of complaints under this policy.
Attachment A.	Revise and enumerate Question 7 from “ ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE? WHAT OUTCOME DO YOU EXPECT FROM FILING YOUR	Revises user instructions on how to complete the form section.	Provides clarity and consistency on the reporting of complaints

Policy Section	Proposed Change	Rationale	Impact
	COMPLAINT?" to "7. WHAT REMEDY DO YOU REQUEST FROM THIS PROCESS? PROVIDE ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE."		under this policy.
Attachment A.	Add acknowledgement: "Employees submitting a complaint to Human Resources are protected from retaliation under policy GA.8027 Harassment, Discrimination, and Retaliation Prevention."	Reminder of the agency's prohibition on unlawful retaliation when engaging in protected activity.	Provides clarity and consistency on the reporting of complaints under this policy.

GA.8036 Education Reimbursement: This policy describes CalOptima Health's pre-approval process for the educational reimbursement program established to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements.

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.	Remove "and assists its" employees and adds to "further and" and "to other positions".	Aligns policy section to the purpose of providing education reimbursement.	Provides clarity and accuracy in program goals.
II.Policy.B.1	Add subsection "Good Standing is verified both at the time of initial request and prior to employee reimbursement."	Aligns policy to practice in determining participant reimbursement eligibility.	Provides clarity and transparency in program eligibility.
II.Policy.C.3	Add subsection "Earn continuing education credits (CEC) towards maintaining a current credential that is required or preferred in their current position or in potential advancement."	Aligns policy to practice in determining educational program eligibility for reimbursement.	Provides clarity and accuracy in program eligibility.
II.Policy.D	Add section "Related activities or supplementary items that are ineligible for education reimbursement include:"	Aligns policy to practice in determining educational program eligibility for reimbursement.	Provides clarity and accuracy in program eligibility.
II.Policy.D	Revise "While continuing education courses that provide	Aligns policy to practice in determining educational program	Provides clarity and accuracy in

Policy Section	Proposed Change	Rationale	Impact
	credit towards renewal of a licensure and/or certification may be eligible for reimbursement under this policy, seminars, conferences, or business meetings that do not result in certification or credit towards a licensure and/or certification are not covered under this policy. Seminars, conferences, and business meetings may be eligible for reimbursement through CalOptima Health’s travel and training process. The costs of new or renewed licensures or certifications are not covered under this policy.” with “1.Seminars, conferences, or other business meetings that do not result in an eligible certification or CEC. 2. Courses, or other programs, involving sports, games, or hobbies. 3. License or certification examination fees and renewal fees of licensures or certifications. 4. Books, stationery, parking, food, travel, education subscriptions, and other miscellaneous fees or expenses are not covered under this policy.”	activities eligible for reimbursement.	program eligibility.
II.Policy.E	Revise “after” to “upon” completing the course or program, adding, “and when they submit their request for reimbursement” to qualify.	Aligns policy to practice with completed coursework reimbursement eligibility.	Provides clarity and transparency in reimbursement eligibility.
II.Policy.F	Revise “Separately, individual departments may budget and pay for the costs of new and/or renewed licensures or certifications required for a job position if budgeted funds are available through the department and at the discretion of the head of the department” to “This policy is not intended to prohibit department leaders from	Describes department leadership role and discretion in reimbursing employees for developmental activities that are outside the scope of this policy.	For consistency and accuracy in the scope of this policy.

Policy Section	Proposed Change	Rationale	Impact
	budgeting or paying for the seminars, business meetings, or examination and renewal costs of the licensures or certifications of their staff at their discretion.”		
II.Policy.G	Revise “An employee must submit a request in advance for both department and Human Resources (HR) approval” to “An employee must submit the completed reimbursement request form to Human Resources prior to the start of the requested course to be eligible for reimbursement. To avoid processing delays, it is recommended that forms be submitted at least three weeks prior to the start of the requested course”. Include a process for how late forms due to delayed departmental approval will be handled.	Aligns policy to practice with employee responsibility in managing their reimbursement request.	Provides clarity and transparency in reimbursement eligibility.
II.Policy.G (original)	Remove original section G “As a condition of reimbursement...”	Assembly Bill 692 places new restrictions on employee repayments to employers for necessitating the removal of the pro rata reimbursement upon separation.	Provides clarity and transparency in reimbursement eligibility.
II.Policy.I	Revise “Education reimbursement is provided in accordance with this policy on a first-come, first-served basis, and only to the extent that budget funds are available. The annual maximum for education reimbursement is calculated for each fiscal year (July 1 – June 30) based on the course end date. The education reimbursement program is not required to be funded” to “Education reimbursement requests are processed on a first-come, first-served basis. The annual maximum employee benefit for education	Aligns policy to practice with reimbursement request processing and perimeters.	Provides consistency and transparency on the handling of reimbursement requests.

Policy Section	Proposed Change	Rationale	Impact
	reimbursement is calculated for each fiscal year (July 1 – June 30) based on the course end date.”		
III.Procedure. Employee.1	Revise “with signatures and submit it to” to “for submission”.	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
III.Procedure. Employee.1.a	Revise “Recommend submission no less than three (3) weeks prior to start date” to “To avoid processing delays, forms should be submitted as soon as feasible and preferably no less than three weeks prior.”	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
III.Procedure. Employee (original)	Remove “Declare major or certification”.	Aligns policy to practice in determining educational program activities eligible for reimbursement.	Provides clarity and accuracy in program eligibility.
III.Procedure. Employee.3.a	Revise “Forms received late as a result of delayed department approval, will not be considered late for the purposes of this policy” to “i. Forms received late solely as a result of delayed department approval will not be considered late for the purposes of the policy. ii. In the event of a delayed department approval, employees must notify Human Resources prior to the start of course.”	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
III.Procedure. Supervisor.1	Add subsection “Review according to policy guidelines and timelines.”	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
III.Procedure. Supervisor.4	Add “in a timely manner”.	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
III.Procedure. Supervisor.5	Add “for a second leader approval”.	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.

Policy Section	Proposed Change	Rationale	Impact
			of reimbursement requests.
III.Procedure. Director/Chief. 1	Add subsection “Review according to policy guidelines and timelines.”	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
III.Procedure. Director/Chief. 2	Add “in a timely manner”.	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
III.Procedure. Director/Chief. 3	Revise “Forward” to “Return completed form to the employee to submit to HR”.	Aligns policy to practice with reimbursement request processing and perimeters.	Provides clarity and consistency on the handling of reimbursement requests.
V.Reference(s) (original)	Remove “CalOptima Health Employee Handbook”.	Handbook references this policy as the source of knowledge.	For clarity and accuracy.
V.Reference(s)	Add “CalOptima Health Policy GA.8033: License and Certification Tracking”.	Aligns with Policy GA.8033 when maintaining the license or certification is a job requirement.	For clarity and accuracy.
IX. Glossary	Add term “Accredited College” defined as “Institution, college, or university accredited by a state, federal, or non-governmental coordinating agency such as the Higher Learning Commission (HLC) or the Western Association of Schools and College – Senior College and University Commission (WSCUC).”	Identifies eligible institutions under this policy.	Provides accuracy and consistency of terms used in policy.
IX. Glossary	Add term “Continuing education credits (CEC)” defined as “Numerical credits assigned to professional training courses, usually on the basis of completion hours used to measure and assign units to licenses or certifications that require those credits for renewal.”	Identifies continuing education credits as an outcome of specific types of training and education required of some licenses and certifications.	Provides accuracy and consistency of terms used in policy.

Policy Section	Proposed Change	Rationale	Impact
IX. Glossary	Add term “Creditable Institution” defined as “Professional organizations, academies, trade groups, and associations that have either formal accreditation such as from the International Accreditors for Continuing Education and Training (IACET) or similar industry recognition as subject matter experts.”	Identifies eligible institutions under this policy.	Provides accuracy and consistency of terms used in policy.
IX. Glossary	Revise definition of Good Standing from “The employee has at least a satisfactory level of performance on their most recent evaluation and has not received written corrective action within the last six (6) month” to “The employee has at least an overall meets expectation level of performance on their most recent evaluation and has not received formal written corrective action within the last six (6) months.”	Aligns employee eligibility to other policies that reference Good Standing as a requirement.	Provides accuracy and consistency of terms used in policy.

GA.8050 Confidentiality: This policy outlines CalOptima Health’s guidelines for protecting proprietary, private, and confidential information.

Policy Section	Proposed Change	Rationale	Impact
II.Policy.B	Reformat Section II.Policy.B into Sections B, C, and D.	Improves readability and adds structure by creating separate sections for proprietary information, private information, and confidential information.	Provides clarity as to the categories of information covered by this policy.
II.Policy.D	Add “Personally Identifiable Information (PII)” as a type of confidential information.	Identifies another example of the type of information that is considered confidential.	Provides clarity and accuracy as to the type of information covered by this policy.
III.Procedure.C	Add Section III.C which states: “C. Consistent with California Penal Code Section 632,	Aligns policy to practice consistent with California Penal Code Section 632 regarding	Provides clarity and accuracy as to the type of information

Policy Section	Proposed Change	Rationale	Impact
	Employees may not secretly record or capture audio, video, or transcription of virtual or in-person workplace conversations or meetings. 1.Training sessions, educational presentations, or other types of special meetings may be recorded by the meeting organizer after notice is provided to all participants. 2.Closed-captioning features may only be used for accessibility and legitimate business purposes. 3.Authorized recordings may be considered public records. They must be created and stored on agency devices and systems subject to AA.1215 Public Records Requests and Subpoenas. 4.Employees are prohibited from recording workplace meetings and conversations on personal devices or storage systems.”	privacy and consent and CalOptima Health policies on use of agency technology and public records.	covered by this policy.
V.Reference(s) C.	Add “CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas” to list of References.	Identifies Policy AA.1215 as a related policy as referenced in Section III. Procedure.C.	Provides clarity and transparency on related policies.
IX. Glossary	Add “Personally Identifiable Information (PII)” as a Glossary term stating, “Information that can distinguish or trace an individual’s identity such as name, email address, Social Security number, date of birth, financial information, educational information, employment information, and other linked information such medical history.” Revise definitions for	Adds a type of confidential information covered under this policy.	Provides accuracy and transparency with terms used in policy.

Policy Section	Proposed Change	Rationale	Impact
	Covered Services, Medical Record, Member, and Provider to include program-specific definitions.		

Fiscal Impact

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

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Adopt Resolution No. 26-1001-01 Approving Updated CalOptima Health Human Resources Policies](#)
2. [CalOptima Health Policy AA.1252: Workforce Engagement and Opportunity](#)
3. [CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention](#)
4. [CalOptima Health Policy GA.8036: Education Reimbursement](#)
5. [CalOptima Health Policy GA.8050: Confidentiality](#)

RESOLUTION NO. 26-1001-01

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

APPROVE UPDATED CALOPTIMA HEALTH HUMAN RESOURCES POLICIES

WHEREAS, Section 13.1 of the CalOptima Health Bylaws provides that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices, and policies for, inter alia, hiring employees and managing personnel;

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima Health employees at will, to set compensation within the boundaries of the budget limits set by the Board of Directors, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to bi-annual review by the Board of Directors, or a committee appointed by the Board of Directors for that purpose; and

WHEREAS, staff has revised certain policies and now presents those revised policies to the Board of Directors for approval.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the following updated CalOptima Health Human Resources policies:

1. AA.1252: Workforce Engagement and Opportunity;
2. GA.8027: Harassment, Discrimination, and Retaliation Prevention;
3. GA.8036: Education Reimbursement; and
4. GA.8050: Confidentiality.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 1st day of October, 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



Policy: AA.1252
Title: Diversity, Equity, Workforce Engagement and Inclusion Opportunity
Department: Human Resources
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2025

Revised Date:

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

I. PURPOSE

This policy describes CalOptima Health's Diversity, Equity, and Inclusion (DEI) commitment to support and advance its health equity strategy by building a diverse and inclusive staff while Workforce Engagement and Opportunity, supporting the organization's health equity initiatives and strategic goals that are aimed at reducing bias by driving opportunities for development and advancement for all Employees. It emphasizes aligning Employee engagement with our mission and improving DEI values and maintaining channels for communication and feedback within the workplace, its Committees, and Governance Bodies workforce.

II. POLICY

A. As part of CalOptima Health's commitment to DEI Workforce Engagement and Opportunity, CalOptima Health shall:

1. Promote best practices in compensation, recruitment and hiring to increase the agency's ongoing commitment to DEI attract and retain a workforce of diverse talents.
2. Build and develop a talented workforce that is reflective meets the service delivery needs of the Orange County community CalOptima Health serves.
3. Maintain Support a consistent workforce Open-Door approach for building a diverse to communication and inclusive staff feedback with Leadership.
4. Provide DEI health outcomes and cultural humility training for all new hires and ongoing training for all Employees at least annually thereafter.

~~B. Our hiring and recruitment practices shall promote Diversity for both Internal and External Applicants, promotions and reclassifications, and temporary and permanent positions.~~

5. Establish an Employee Engagement Team for invited employees to share ideas, strategies, and activities to enhance Employee engagement.

~~C. B.~~ CalOptima Health shall regularly periodically evaluate, at a minimum, the following:

1. How our workforce ~~reflects the Diversity of~~meets the needs of our population served.

~~2. Which groups are inadequately represented in the workforce.~~

~~3.2. Whether specific groups are marginalized, disenfranchised or disempowered by our recruitment and hiring practices~~functions or departments have staffing gaps.

~~3. How Employee engagement supports organizational programs and plans for serving Members.~~

~~D. CalOptima Health shall ensure that our hiring and recruitment policies explicitly address how CalOptima Health promotes Diversity for our staff, Leadership, and Committees.~~
~~may~~

~~E.C. CalOptima Health shall conduct an analysis at least annually a range of surveys, interviews, and questionnaires to identify workforce engagement and development opportunities to improve Diversity, Equity, Inclusion such as 360 feedback review, training needs assessments, benefit and wellness plan surveys, exit interviews, focus groups, and/or Cultural Humility for staff, Leadership, Governance Bodies, and Committees. Employee engagement surveys.~~

~~F.1. CalOptima Health This data shall be used to implement interventions to, address identified gaps and opportunities to improve Diversity, Equity, Inclusion and Cultural Humility for at least one of the groups (staff, Leadership, Committees or Governance Bodies), eliminate barriers to workforce engagement and development.~~

III. PROCEDURE

A. Hiring and Recruiting

~~1. Staff and Leadership~~

~~a.1. CalOptima Health ensures that its compensation, hiring and recruitment process promotes Diversity considers opportunities for the staff career development and future Leadership positions needs in accordance with the provisions in CalOptima Health Policy Policies GA.8060: Recruitment, Selection, and Hiring and GA.8057: Compensation Program.~~

~~a. To promote Diversity and Inclusion, the organization Human Resources may periodically select posted vacancies for greater internal visibility by spotlighting them to all Employees as opportunities for advancement.~~

~~b. CalOptima Health will develop and maintain all:~~

~~i.b. Job Descriptions to include the following:~~

~~a)i. Gender-neutral language;~~

~~b) Salary range for each position;~~

~~ii. Mobility Fair Labor Standards Act (FLSA) Status;~~

~~iii. Work environment description;~~

~~e)iv. Physical demands including mobility requirements; and~~

1
2 d)v. ~~Reduce the requirements of each position to~~Only the “must-have” qualifications for
3 the position.
4

5 ii. ~~Job Announcements to include the following:~~

- 6
7 a) ~~Non-discrimination based on race, age sex, gender identity, disability, religion, and~~
8 ~~other enumerated protected characteristics as defined by law;~~
9
10 b) ~~The organization’s commitment to Diversity and Inclusion;~~
11
12 c) ~~Equal Employment Opportunity Statement; and~~
13
14 d) ~~Reasonable Accommodation Announcement.~~

15
16 ~~2. Committee Membership-~~

17
18 a. ~~CalOptima Health shall ensure that its hiring and recruitment process promotes Diversity in~~
19 ~~its Quality Improvement Health Equity Committee (QIHEC) and its reporting~~
20 ~~subcommittees listed below:~~

21
22 i. ~~Utilization Management Committee;~~

23
24 ii. ~~Whole Child Model Clinical Advisory Committee (WCM-CAC);~~

25
26 iii. ~~Credentialing and Peer Review Committee (CPRC);~~

27
28 iv. ~~Population Health Management Committee (PHMC);~~

29
30 v. ~~Grievances and Appeals Resolutions Services Committee (GARS); and~~

31
32 vi. ~~Member Experience Committee (MEMx);~~

33
34 b. ~~At a minimum, the seven (7) Committees will include a broad range of~~
35 ~~practitioners/providers and representatives from the community.~~

36
37 c. ~~At least annually, CalOptima Health’s Chief Medical Officer (CMO) or designee shall review~~
38 ~~and assess Committee membership composition to ensure representation from a diverse~~
39 ~~group of network providers and community representatives, in accordance with Policy~~
40 ~~GG.1620: Quality Improvement and Health Equity Committee, and in alignment with its~~
41 ~~membership composition.~~

42
43 d. ~~The CMO or designee shall request for consideration, nominees that represent groups~~
44 ~~identified as being inadequately represented or underrepresented in the Committee, or~~
45 ~~groups identified as marginalized, disenfranchised or disempowered.~~

46
47 e. ~~In addition, all nominees shall be vetted to ensure that they meet the following criteria:~~

48
49 i. ~~Represent a health network or community organization that provides health care~~
50 ~~services and/or community support to CalOptima Health Members;~~

51
52 ii. ~~Meet minimum experience/qualifications as noted in the bylaws;~~
53

1 iii. ~~Are in good standing with CalOptima Health; and~~

2
3 iv. ~~Do not have a conflict of interest that would prohibit Committee participation.~~

4
5 f. ~~The CMO or designee, with input from other Committee members, shall select the most~~
6 ~~suitable candidate to participate on the Committee.~~

7
8 3. ~~Governance Body~~

9
10 a. ~~CalOptima Health's Governing Body is the Board of Directors (BOD), and all seats of the~~
11 ~~BOD are appointed by the Orange County Board of Supervisors, in accordance with~~
12 ~~Ordinance No. 16-001.~~

13
14 b. ~~CalOptima Health has no authority or jurisdiction over the recruiting, hiring, or seating of~~
15 ~~the members of the BOD.~~

16
17 B. ~~Recruitment and Selection:~~

18
19 1. ~~To promote equal employment opportunity in the recruitment and selection of all qualified~~
20 ~~applicants, all vacant positions will be posted in accordance with CalOptima Health's merit-~~
21 ~~based, fair hiring policies and procedures described in CalOptima Health Policies GA.8025:~~
22 ~~Equal Employment Opportunity, GA.8030: Background Check, and GA.8060: Recruitment,~~
23 ~~Selection, and Hiring.~~

24
25 D. ~~Performance Measures, Analysis and Reporting~~

26
27 1.2. ~~To monitor its hiring and recruiting processes, CalOptima Health will~~ ~~assess the~~
28 ~~performance~~ maintain a dashboard ~~using the following measures:~~

29
30 a. Internal Fill Rate (%);

31
32 b. Organizational Demographics;

33
34 a. ~~Position Vacancy Rate (%);~~

35
36 b.c. ~~Time to Fill Vacancy (days); and~~

37
38 e.d. ~~Turnover Rate (%).~~

39
40 B. Open Door Approach:

41
42 2. ~~CalOptima Health To promote Culturally and Linguistically Appropriate Services (CLAS) and~~
43 ~~DEI, the organization performs the following tasks:-~~

44
45 a. ~~Collects and analyzes race/ethnicity, gender, age, and language data for staff and~~
46 ~~Leadership and compares it against the population served with the goal of the organization~~
47 ~~being representative of Orange County.~~

48
49 b. ~~Collects and analyzes race/ethnicity and gender data for Committees and Governing Bodies~~
50 ~~and compares it against the population served with the goal of being reflective of Orange~~
51 ~~County.~~

52 e. ~~Uses the data to identify groups that are inadequately represented in the workforce.~~
53

3. ~~CalOptima Health monitors these metrics on an ongoing basis and analyzes the aggregated results at least annually against the goals.~~

4. ~~CalOptima Health conducts qualitative analysis that includes identification of barriers, opportunities for improvement and actions or interventions to improve CLAS and DEI in recruiting practices.~~

5. ~~CalOptima Health prioritizes the opportunities and actions to determine focus for the year for each of the groups.~~

6. ~~CalOptima Health re-measures and analyzes the results of these metrics every year to assess whether identified actions and interventions were successful and will determine the need to discontinue, modify or implement new interventions.~~

1. encourages Employees to ask questions and share their opinions, ideas, and feedback regarding decisions affecting them or their job responsibilities to improve operations with their department leaders, Human Resources, or Chief Executive Officer (CEO).

a. Employees may engage in the Open Door Approach using any of the available communication channels including email, telephone, Teams, and in-person.

b. CalOptima Health will keep inquiries confidential to the extent possible based on a review of the business and legal obligations.

c. Retaliation against any employee for raising a concern or participating in an inquiry is prohibited under CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention policy.

E.C. Training and Development:

1. ~~CalOptima Health provides training to recruiters and hiring managers in recognizing unconscious biases in interviews and conducting standardized interviews to minimize the impact possibility of unconscious biases and discrimination during the interview phase impacting hiring decisions.~~

2. ~~CalOptima Health Human Resources provides training the learning management system to host trainings, in accordance with CalOptima Health Policy AA.1251: Diversity, Equity and Inclusion Health Outcomes Training Program, as follows:~~

a. New Employees, including Leadership, complete training within ninety (90) days of hire.

b. Existing Employees, including Leadership, complete the training ~~annually~~ biannually.

3. CalOptima Health will provide trans-inclusive health care cultural competency training to be completed within forty-five (45) days for newly hired ~~staff~~ Employees and every two (2) years thereafter.

4. CalOptima Health offers optional self-selected training to all Employees on topics relating to CLAS health outcomes and DEI our CARES Values in both instructor led and eLearning formats.

- a. Human Resources shall maintain an inventory of required and optional training courses offered in the learning management system (LMS). Courses completed in the LMS are recorded and part of the Employees' training transcript.

D. Employee Engagement Team

CalOptima Health

1. may establish a workgroup of staff and executive Leadership to communicate ideas and strategies, and conduct activities to enhance Workforce Engagement and Opportunity.
2. Human Resources will maintain the Employee Engagement Team Charter.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Policy AA.1251: ~~Diversity, Equity, and Inclusion~~ Health Outcomes Training Program
- A.B. CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention
- B. CalOptima Health Policy GA.8019: Promotions and Transfers
- C. CalOptima Health Policy GA.8022: Performance and Behavior Standards8057: Compensation Program
- D. CalOptima Health Policy GA.8030: Background Check
- E.D. CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring
- F. CalOptima Health Policy GG.1620: Quality Improvement and Health Equity Committee (QIHEC)
- E. Covered California Contract Attachment 1, Section 1.04.2 Workforce
- G.F. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-016: Diversity, Equity, and ~~And~~ Inclusion Training Program Requirements -(Supersedes APL 23-025)
- H.G. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-017: Transgender, Gender Diverse Or Intersex Cultural Competency Training Program and Provider Directory Requirements
- H. Employee Engagement Team Charter
- I. NCQA Standards for the Accreditation: Health ~~Equity Standards~~ Outcomes Accreditation

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
04/03/2025	Regular Meeting of the CalOptima Health Board of Directors
	<u>Regular Meeting of the CalOptima Health Board of Directors</u>

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	AA.1252	Diversity, Equity, and Inclusion	Administrative
Revised	04/03/2025	AA.1252	Diversity, Equity, and Inclusion	Administrative

Action	Date	Policy	Policy Title	Program(s)
<u>Revised</u>		<u>AA.1252</u>	<u>Workforce Engagement and Opportunity</u>	<u>Administrative</u>

1

For 20261001 BOD Review Only

IX. GLOSSARY

Term	Definition
<u>Committee</u>	Group of individuals, who may be employees and/or external to the organization, appointed for a specific function.
<u>Cultural Humility</u> <u>CARES Values</u>	Ability of organizations, systems, and health care professionals to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services. CalOptima Health's core values of Collaboration, Accountability, Respect, Excellence, and Stewardship.
<u>Diversity</u>	Describes the presence of differences (e.g., race/ethnicity, preferred language, gender identity, sexual orientation, age, mobility) in the pool of candidates for employment opportunities that reflects the population served.
<u>Employee</u>	Any and all employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
<u>Equity</u>	Developing, strengthening and supporting procedural and outcome fairness in systems, procedure and resource distribution mechanisms to create fair opportunities for all individuals. Equity and "equitable" are distinct from equality or "equal", which refers to everyone having the same treatment but does not account for different needs to circumstances. Equity focus on eliminating barriers that have prevented the full participation of historically and currently oppressed groups.
<u>External Applicant</u>	Applicants to recruitments who are not employed by the organization.
<u>Governance Body</u>	The organization's board of directors, which is responsible for organizational governance.
<u>Inclusion</u>	Intentionally designed, active and ongoing engagement with individuals that ensures opportunities and pathways for participation in all aspects of a group, organization or community, including decision-making processes. Inclusion refers to how groups show that individuals are valued as respected members of the group, team, organization or community and is often created through progressive, consistent actions to expand, include and share.
<u>Internal Applicant</u> <u>Fill Rate</u>	Applicants to recruitments who are currently employed by the organization. Percentage of total open positions filled by existing employees.
<u>Leadership</u>	Employees in a position with managerial authority and/or executive roles such as supervisors, managers, directors, medical directors, executive directors or chief officers.
<u>Member</u>	A beneficiary <u>An individual</u> who is enrolled in a CalOptima Health program.
<u>Organizational Demographics</u>	CalOptima Health census data of employee age, gender, and ethnicity categories.
<u>New Position</u> <u>Vacancy Rate</u>	Position that has not been available with the organization previously, any position with a new title, job duties and/or wage change may be considered a new position and includes full time, part time, and temporary/seasonal positions. Percentage of open positions as compared to budgeted positions.

Term	Definition
<u>Committee</u>	<u>Group of individuals, who may be employees and/or external to the organization, appointed for a specific function.</u>
<u>Cultural Humility</u> <u>CARES Values</u>	<u>Ability of organizations, systems, and health care professionals to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.</u> <u>CalOptima Health's core values of Collaboration, Accountability, Respect, Excellence, and Stewardship.</u>
<u>Turnover Rate</u>	<u>Number of separated employees as compared to the average number of total employees in a given period.</u>
<u>Quality Improvement Health Equity Committee (QHIEC)</u> <u>Workforce Engagement and Opportunity</u>	<u>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 (QHETP) findings and required actions.</u> <u>Developing and supporting our Employee's commitment and connection to the mission, values, members, and one another through purposeful and meaningful work, trusted and valued relationships, and opportunities for professional growth and development.</u>

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Policy: AA.1252
Title: **Workforce Engagement and Opportunity**
Department: Human Resources
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2025

Revised Date:

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

I. PURPOSE

This policy describes CalOptima Health's commitment to Workforce Engagement and Opportunity, supporting the organization's health initiatives and strategic goals by driving opportunities for development and advancement for all Employees. It emphasizes aligning Employee engagement with our mission and values and maintaining channels for communication and feedback within the workforce.

II. POLICY

A. As part of CalOptima Health's commitment to Workforce Engagement and Opportunity, CalOptima Health shall:

1. Promote best practices in compensation, recruitment and hiring to increase the agency's ongoing commitment to attract and retain a workforce of diverse talents.
2. Build and develop a talented workforce that meets the service delivery needs of the Orange County community CalOptima Health serves.
3. Support a workforce Open-Door approach to communication and feedback with Leadership.
4. Provide health outcomes and cultural humility training for all new hires and ongoing training for all Employees.
5. Establish an Employee Engagement Team for invited employees to share ideas, strategies, and activities to enhance Employee engagement.

B. CalOptima Health shall periodically evaluate the following:

1. How our workforce meets the needs of our population served.
2. Whether specific functions or departments have staffing gaps.
3. How Employee engagement supports organizational programs and plans for serving Members.

C. CalOptima Health may conduct a range of surveys, interviews, and questionnaires to identify workforce engagement and development opportunities such as 360 feedback review, training needs assessments, benefit and wellness plan surveys, exit interviews, focus groups, and Employee engagement surveys.

1. This data shall be used to implement interventions, address identified gaps and opportunities and eliminate barriers to workforce engagement and development.

III. PROCEDURE

A. Hiring and Recruiting

1. CalOptima Health ensures that its compensation, hiring and recruitment process considers opportunities for career development and future Leadership needs in accordance with the provisions in CalOptima Health Policies GA.8060: Recruitment, Selection, and Hiring and GA.8057: Compensation Program.
 - a. Human Resources may periodically select posted vacancies for greater internal visibility by spotlighting them to all Employees as opportunities for advancement.
 - b. CalOptima Health will develop and maintain Job Descriptions to include the following:
 - i. Gender-neutral language;
 - ii. Fair Labor Standards Act (FLSA) Status;
 - iii. Work environment description;
 - iv. Physical demands including mobility requirements; and
 - v. Only the “must-have” qualifications for the position.
2. To monitor its hiring and recruiting processes, CalOptima Health will maintain a dashboard using the following measures:
 - a. Internal Fill Rate (%);
 - b. Organizational Demographics;
 - c. Position Vacancy Rate (%); and
 - d. Turnover Rate (%).

B. Open Door Approach:

1. CalOptima Health encourages Employees to ask questions and share their opinions, ideas, and feedback regarding decisions affecting them or their job responsibilities to improve operations with their department leaders, Human Resources, or Chief Executive Officer (CEO).
 - a. Employees may engage in the Open Door Approach using any of the available communication channels including email, telephone, Teams, and in-person.

- 1 b. CalOptima Health will keep inquiries confidential to the extent possible based on a review
2 of the business and legal obligations.
3
4 c. Retaliation against any employee for raising a concern or participating in an inquiry is
5 prohibited under CalOptima Health Policy GA.8027: Harassment, Discrimination, and
6 Retaliation Prevention.
7

8 C. Training and Development:
9

- 10 1. CalOptima Health provides training to recruiters and hiring managers in recognizing
11 unconscious biases in interviews and conducts standardized interviews to minimize the
12 possibility of unconscious biases impacting hiring decisions.
13
14 2. Human Resources provides the learning management system to host trainings, in accordance
15 with CalOptima Health Policy AA.1251: Health Outcomes Training Program, as follows:
16
17 a. New Employees, including Leadership, complete training within ninety (90) days of hire.
18
19 b. Existing Employees, including Leadership, complete the training biannually.
20
21 3. CalOptima Health will provide trans-inclusive health care cultural competency training to be
22 completed within forty-five (45) days for newly hired Employees and every two (2) years
23 thereafter.
24
25 4. CalOptima Health offers optional self-selected training to all Employees on topics relating to
26 health outcomes and our CARES Values in both instructor led and eLearning formats.
27
28 a. Human Resources shall maintain an inventory of required and optional training courses
29 offered in the learning management system (LMS). Courses completed in the LMS are
30 recorded and part of the Employees' training transcript.
31

32 D. Employee Engagement Team
33

- 34 1. CalOptima Health may establish a workgroup of staff and executive Leadership to communicate
35 ideas and strategies, and conduct activities to enhance Workforce Engagement and Opportunity.
36
37 2. Human Resources will maintain the Employee Engagement Team Charter.
38

39 IV. ATTACHMENT(S)
40

41 Not Applicable
42

43 V. REFERENCE(S)
44

- 45 A. CalOptima Health Policy AA.1251: Health Outcomes Training Program
46 B. CalOptima Health Policy GA.8027: Harassment, Discrimination, and Retaliation Prevention
47 C. CalOptima Health Policy GA.8057: Compensation Program
48 D. CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring
49 E. Covered California Contract Attachment 1 Section 1.04.2 Workforce
50 F. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-016: Diversity, Equity, And
51 Inclusion Training Program Requirements (Supersedes APL 23-025)
52 G. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-017: Transgender, Gender
53 Diverse Or Intersex Cultural Competency Training Program and Provider Directory Requirements
54 H. Employee Engagement Team Charter

I. NCQA Standards for the Accreditation: Health Outcomes Accreditation

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
04/03/2025	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	01/01/2025	AA.1252	Diversity Equity, and Inclusion	Administrative
Revised	04/03/2025	AA.1252	Diversity, Equity, and Inclusion	Administrative
Revised		AA.1252	Workforce Engagement and Opportunity	Administrative

1 IX. GLOSSARY

2

Term	Definition
CARES Values	CalOptima Health's core values of Collaboration, Accountability, Respect, Excellence, and Stewardship.
Employee	Any and all employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
Internal Fill Rate	Percentage of total open positions filled by existing employees.
Leadership	Employees in a position with managerial authority and/or executive roles such as supervisors, managers, directors, medical directors, executive directors or chief officers.
Member	An individual who is enrolled in a CalOptima Health program.
Organizational Demographics	CalOptima Health census data of employee age, gender, and ethnicity categories.
Position Vacancy Rate	Percentage of open positions as compared to budgeted positions.
Turnover Rate	Number of separated employees as compared to the average number of total employees in a given period.
Workforce Engagement and Opportunity	Developing and supporting our Employee's commitment and connection to the mission, values, members, and one another through purposeful and meaningful work, trusted and valued relationships, and opportunities for professional growth and development.

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4



Policy: GA.8027
Title: **Harassment, Discrimination, and Retaliation Prevention**
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

I. PURPOSE

This policy outlines CalOptima Health's zero tolerance for Discrimination, Harassment, and Retaliation and sets forth a procedure for promptly investigating complaints thereof.

II. POLICY

- A. CalOptima Health is committed to providing a professional work environment that is free of Discrimination and Harassment based on one or more protected category(ies), and an environment free from Retaliation for participating in any protected activity(ies) covered by this policy and CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.
- B. CalOptima Health is committed to providing equal employment opportunities to all Employees and applicants for employment. Accordingly, CalOptima Health has adopted and shall maintain this policy to encourage professional and respectful behavior and prevent discriminating, Harassing, or retaliatory conduct in our workplace. CalOptima Health shall implement appropriate corrective action(s), up to and including termination, in response to any violation of this policy, even if the violation does not rise to the level of unlawful conduct.
- C. CalOptima Health prohibits Discrimination and Harassment based on the following categories: race, color, traits historically associated with race such as hair texture and style, religion, religious creed (including religious observance, dress and grooming practices), national origin, ancestry, citizenship, physical or mental disability, perceived disability, history of disability, medical condition (including cancer and genetic characteristics), genetic information, marital status, registered domestic partner status, sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, gender, transitioning status, gender identity, gender expression, age (40 years and over), sexual orientation, veteran and/or military status, protected medical leaves (requesting or taking leave under the Family and Medical Leave Act or the California Family Rights Act), survivor or family member of a victim of violence and certain crimes, political affiliation, time off work for mandatory jury duty service, perception that anyone has any of those characteristics, association with anyone that has any of those characteristics, and any other status protected by state or federal law. In addition, CalOptima Health prohibits Retaliation against a person who engages reasonably and in good faith in activities protected under this policy in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for

Reporting Violations. Reporting or assisting in reporting suspected violations of this policy and cooperating in investigations or proceedings arising out of an alleged violation of this policy are protected activities.

- D. All Employees are expected to assume responsibility for maintaining a work environment that is free from Discrimination, Harassment and Retaliation. The law prohibits Employees at all levels, as well as third parties with whom CalOptima Health Employees come into contact in the workplace, from engaging in unlawful Discrimination, Harassment and Retaliation. Employees are encouraged to promptly report conduct that they reasonably believe violates this policy so that CalOptima Health shall have an opportunity to address and resolve any concerns. Managers and supervisors are required to promptly report conduct that they believe violates this policy to the Human Resources Department. CalOptima Health is committed to responding to alleged violations of this policy in a timely and fair manner and to taking appropriate action aimed at ending the prohibited conduct.
- E. Complaints/reports under this policy must be based on a reasonable belief of misconduct and made in good faith. CalOptima Health will not tolerate intentional false accusations of Discrimination, Harassment, or Retaliation. The finding of any intentional false accusation is considered a violation of this policy and may result in corrective action up to and including termination.
- F. This policy applies to agents, contractors, volunteers, job applicants, and Employees. In addition, this policy extends to conduct with a connection to an Employee's work, even when the conduct takes place away from CalOptima Health's premises, such as a business trip or business-related social function. Harassment, Discrimination, and/or Retaliation can occur between individuals in different work locations including but not limited to in person, working remotely, on virtual platforms, in messaging apps, and after working hours between personal cell phones. Remote work locations, virtual platforms, social media, and text/email communications are considered part of the workplace for purposes of this policy. CalOptima Health's policy prohibiting Discrimination against CalOptima Health Members is addressed in CalOptima Health Policy HH.1104: Complaints of Discrimination.
- G. CalOptima Health shall take appropriate steps and implement processes to protect Employees from unlawful Discrimination, Harassment and Retaliation in the workplace, including:
1. Employees are encouraged to timely report and file a complaint regarding suspected or actual inappropriate conduct in violation of this policy and/or applicable laws, and, whenever possible, to put the complaint or concern in writing. Employees may designate the report or complaint as confidential, which may remain confidential to the extent possible based on the circumstances and applicable laws, except with respect to the investigation, which may not be completely confidential. Employees can file complaints directly with their immediate supervisor, manager, or the Human Resources Department.
 2. Supervisors and managers are required to forward all complaints, oral and/or written, alleging violation(s) of this policy to the Human Resources Department. Leaders and investigators may not promise absolute confidentiality and must disclose information as needed to conduct a fair investigation.
 3. The Human Resources Department or designee will review any report or complaint of inappropriate conduct in violation of this policy and will complete a timely, thorough, and impartial review and/or investigation, when appropriate, that provides all parties with an opportunity to be heard and reaches reasonable conclusions based on the evidence collected.
 4. Impacted parties are required to reasonably participate in good faith in the review and/or

investigation of complaints alleging inappropriate conduct in violation of this policy.

5. The complainant and respondent will be timely informed of appropriate information related to the progress of the review or investigation, including the findings and closure of an investigation.
 6. If, at the end of the investigation, inappropriate conduct or violation(s) of this policy or applicable law are found, CalOptima Health shall take appropriate remedial measures.
 7. Employees reporting inappropriate conduct, along with Employees participating in the investigation as witnesses, shall not be retaliated against for filing a complaint or participating in the investigation process.
- H. Employees may also file a complaint directly with the United States Equal Employment Opportunity Commission (EEOC) or California Civil Rights Department (CRD) or other appropriate state or federal agency(ies). They may also file a civil action in the appropriate court, subject to applicable laws.
- I. Prohibited Conduct
1. Discrimination: CalOptima Health prohibits Discrimination based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited Discrimination includes unequal treatment based upon the Employee or applicant's association with a member of these protected classes. Discrimination may include but is not necessarily limited to allowing the applicant's or Employee's protected category to be a factor in hiring, promotion, compensation, or other employment related decision, unless otherwise permitted by applicable law; and providing unwarranted assistance or withholding work-related assistance, cooperation, and/or information to applicants or Employees because of their protected category.
 2. Harassment: CalOptima Health prohibits Harassing, disrespectful or unprofessional conduct, including Harassing, disrespectful or unprofessional conduct based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited Harassment can be verbal (such as slurs, jokes, insults, epithets, gestures, or teasing), visual (such as the posting or distribution of offensive posters, symbols, cartoons, drawings, computer displays, or emails), or physical (such as physically threatening another person, blocking someone's way, making physical contact in an unwelcome manner, etc.).
 - a. Sexual Harassment: CalOptima Health prohibits Discrimination and Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, sexual orientation, gender, gender identity, or gender expression. Sexually Harassing conduct need not be motivated by sexual desire and may include situations that began as reciprocal relationships, but that later cease to be reciprocal. Sexual Harassment may involve Harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity. Prohibited Sexual Harassment falls into two categories: (1) "*quid pro quo*" ("this for that") when someone conditions a job, promotion, or other work benefit based on submission to sexual advances or other conduct based on sex; or (2) "hostile work environment" when unwelcome comments or conduct based on sex unreasonably interferes with your work performance or creates an intimidating, hostile, or offensive work environment. Prohibited Sexual Harassment may include all the actions described above as Harassment, as well as other unwelcome sex-based conduct, such as, but not limited to:

- i. Unwelcome or unsolicited sexual advances;
- ii. Offering employment benefits in exchange for sexual favors;
- iii. Leering or gestures;
- iv. Displaying or sharing sexually suggestive objects, pictures, GIFs, cartoons, videos, or posters;
- v. Derogatory comments, chat messages, epithets, slurs, memes, or jokes;
- vi. Graphic comments, sexually degrading words, conversations regarding sexual activities, verbal abuse of a sexual nature, or suggestive or obscene messages or invitations;
- vii. Physical touching or assault, as well as impeding or blocking movements, or other verbal or physical conduct of a sexual nature;
- viii. Making or threatening retaliatory action after receiving a negative response to a sexual advance;
- ix. Cyberstalking or repeatedly contacting an Employee online with sexual messages; or
- x. Sending unwanted messages of a sexual nature through social media if the conduct is connected to the workplace or affects the Employee's work environment.

b. Abusive Conduct: CalOptima Health prohibits conduct of an employer or Employee in the workplace, with malice, that a reasonable person would find hostile, offensive, and unrelated to an employer's legitimate business interests. Engaging in a pattern of one or more of the following behaviors meets the definition of abusive conduct under California law. The use of inappropriate language, put-downs, insults and name-calling, taunting, teasing, or making jokes about a co-worker when the intent is to embarrass and humiliate. Sabotaging another Employee's work or copying, plagiarizing, or stealing work from a co-worker and passing it off as one's own.

3. Retaliation: CalOptima Health prohibits Retaliation against an Employee because the Employee has engaged in protected activity. Protected activities may include, but are not limited to, reporting or assisting in reporting suspected violations of this policy, CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations or other applicable laws, and/or cooperating in investigations or proceedings arising out of an alleged violation or other applicable laws. CalOptima Health shall not take any adverse employment action, based on the Employee's protected activity, that materially affects the terms and conditions of the Employee's employment status or is reasonably likely to deter the Employee from engaging in protected activity. Examples of Retaliation under this policy include, but are not limited to: demotion; suspension; reduction in pay; termination; denial of a merit salary increase; failure to hire or consider for hire; refusing to promote or consider for promotion because of reporting a violation of this policy; Harassing another Employee for filing a complaint; denying employment opportunities for making a complaint or cooperating in an investigation; changing someone's work assignments; treating people differently such as denying an accommodation; not talking to an Employee when otherwise required by job duties; or otherwise excluding the Employee from job-related activities because of engagement in activities protected under this policy. Actual or threatened Retaliation for rejecting sexual advances or complaining about Sexual Harassment is also unlawful and a

violation of this policy and CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

- J. CalOptima Health shall disseminate this policy to all Employees and require them to acknowledge electronically that each individual has received and understands the policy. All legally required posters shall be posted in a prominent and accessible location in the workplace.

K. Online activities conducted during work hours or for work-related purposes are considered part of the workplace and are subject to the CalOptima Health Harassment, Discrimination, and Retaliation Prevention policy.

K.L. Training Requirements

1. All non-management/non-supervisory Employees are required to attend Harassment prevention training for Employees (1 hour) within the first six (6) months of hire and at least every two (2) years thereafter.
2. All management/supervisory Employees must complete the Harassment prevention training for leaders (2 hours) within the first six (6) months of hire and at least every two (2) years thereafter. These trainings shall include prevention of abusive conduct in the workplace.

L.M. Addressing and Reporting Violations

1. Any Employee or applicant who experiences behavior that they believe violates this policy is encouraged to immediately tell the offending individual that the behavior is inappropriate and, if they feel comfortable doing so, to tell the offending individual to stop the behavior.
2. Any Employee witnessing Harassment is encouraged to report it. There are five (5) standard methods of intervention that can be used when anyone witnesses Harassment or Discrimination and wants to help. A witness:
 - a. Can interrupt the Harassment by engaging with the individual being Harassed and distracting them from the Harassing behavior;
 - i. Who feels unsafe interrupting on their own can ask a third party to help intervene in the Harassment;
 - b. Can document the Harassment incident to benefit a future investigation;
 - c. Might check in with the person who has been Harassed after the incident, let them know the behavior was not appropriate, and encourage the person to report it; and/or
 - d. If feeling safe, can advise the harasser that the behavior was inappropriate. Effective intervention focuses on de-escalation through words and non-physical actions.
3. The applicant, witness, or Employee should also immediately report the alleged violation to their supervisor, manager, or the Human Resources Department. They are free to contact the Human Resources Department and are not required to request supervisor or manager approval to do this. If the alleged offender is the Employee's supervisor or manager, the Employee should report the conduct to any other supervisor or manager or the Human Resources Department. A complaint may be brought forward verbally or in writing. Written complaints can be made using, but not limited to, the Employee Complaint Intake Form.

4. Supervisors or managers who learn of any potential violation of this policy are required to immediately report the matter to Human Resources and must follow instructions provided by Human Resources as to how best to proceed.

5. CalOptima Health shall promptly look into the facts and circumstances of any alleged violation, as appropriate. Where the reported behavior does not rise to the level of violating this policy, CalOptima Health may resolve the issue informally, for example, through counseling. If the report contains allegations of conduct that may violate this policy, a formal investigation will be conducted to determine the facts. Even in the absence of a formal complaint, CalOptima Health will initiate an investigation where it has reason to believe that conduct that violates this policy has occurred. Moreover, even where a complainant conveys a request to withdraw their initial complaint, CalOptima Health will continue the investigation to ensure that the workplace is free from Harassment.

5-6. Anonymous complaints shall also be investigated. The method will depend on the details provided in the anonymous complaint. If the complaint is sufficiently detailed, the investigation may be able to proceed in the same manner as any other complaint. If the information is more general, CalOptima Health may do an environmental assessment or survey to try to determine if misconduct has occurred. All investigations will be fair, impartial, timely, and completed by qualified personnel.

6-7. To the extent possible, CalOptima Health shall endeavor to keep the applicant or Employee's concerns confidential; however, complete confidentiality cannot be guaranteed when it interferes with CalOptima Health's ability to fulfill its obligations under this policy. All Employees are required to cooperate fully and in good faith with any investigation. This includes, but is not limited to, maintaining an appropriate level of discretion regarding the investigation, and disclosing any and all information that may be pertinent to the investigation. Upon completion of the investigation, if misconduct is substantiated, CalOptima Health shall take appropriate corrective and preventive action calculated to end the conduct up to and including formal corrective action where warranted.

M.N. Filing of Complaints Outside of CalOptima Health

1. Employees and applicants may file formal complaints of Discrimination, Harassment, or Retaliation with the agencies listed below. Individuals who wish to pursue filing with these agencies should contact them directly to obtain further information about their processes and time limits.

a. **California Civil Rights Department**

2218 Kausen Drive Suite 100
Elk Grove CA 95758

800-884-1684 (voice), 800-700-2320 (TTY) or California's Relay Service at 711
contact.center@calcivilrights.ca.gov <https://calcivilrights.ca.gov/>

b. **U.S. Equal Employment Opportunity Commission**

450 Golden Gate Avenue 5 West
PO Box 36025
San Francisco CA 94102-3661

1-800-669-4000 or 510-735-8909 (Deaf/hard-of-hearing callers only)
<https://www.eeoc.gov/employees>

- 1 2. Employees or applicants who believe they have been the subject of Discrimination, Harassment
2 or Retaliation for making a complaint or participating in an investigation of Discrimination or
3 Harassment may file a complaint with the CRD within three (3) years of the last act of
4 Discrimination, Harassment or Retaliation. CRD serves as a neutral factfinder and attempts to
5 help the parties voluntarily resolve disputes. CRD may also file a civil complaint and seek court
6 orders changing the employer's policies and practices, and awarding attorney's fees and costs.
7 Employees can also pursue the matter through a private lawsuit in civil court after a complaint
8 has been filed and a Right-to-Sue Notice has been issued.
9

10 **III. PROCEDURE**
11

Responsible Party	Action
Employee	- Assume responsibility for a work environment free from Discrimination, Harassment and Retaliation. - Report the facts of any incident(s) of Discrimination or Harassment based on a protected characteristic or Retaliation based on a protected activity immediately to your supervisor, manager, or the Human Resources (HR) Department. - Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation.
Supervisor	- Gather all relevant facts from reporting Employee and report it immediately to the HR Department. - Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation. - Keep reports or complaints of Discrimination, Harassment, or Retaliation confidential, to the extent possible, and follow HR's direction and guidance.

Responsible Party	Action
Human Resources	▪ Upon receipt of a complaint, evaluate the reported misconduct and determine what level of review or investigation is needed and appropriate for the circumstances. ▪ Request supporting documentation and/or additional statements from Employees and potential witnesses, where applicable. ▪ If a determination is made that no further <u>review or</u> investigation is required, a closure notice shall be issued to the complainant documenting the decision. ▪ If a determination is made that an investigation is required, complete an impartial, timely, and thorough investigation of the complaint, which may include interviewing the complaining party, responding party, and relevant witnesses. ▪ Review collected documents, exhibits or other evidence. Analyze the information, make <u>Credibility</u> determinations when needed, reach reasonable conclusions based on the evidence collected, and make findings based on a <u>Preponderance</u> of the <u>Evidence Standard</u>. ▪ If misconduct is found, recommend appropriate remedial measures, along with preventive and/or corrective action, when it is warranted, to department leadership. ▪ Timely inform the complainant of the conclusion of the investigation and any findings. ▪ Timely inform the <u>accused</u> party of the conclusion of the investigation, any findings, and the final decision, if applicable, of remedial measures or preventive and/or corrective action. ▪ HR will strive to maintain confidentiality during the investigation, but there is no guarantee of complete confidentiality. Only the parties who need to know shall be involved.

IV. ATTACHMENT(S)

A. Employee Incident / Complaint Intake Form

V. REFERENCE(S)

- A. CalOptima Health Policy GA.8044: Telework Program
- B. CalOptima Health Policy GA.8062: Social Media Conduct
- C. CalOptima Health Policy HH.1104: Complaints of Discrimination
- D. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
- E. California Government Code, §§12926, 12935, 12940 *et seq.*, 12950, and 12950.1.
- F. Title 2, California Code of Regulations (C.C.R.), §§11008 *et seq.*, 11023, 11027.1(a) and (b), and 1030(a)-(f)
- G. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq.*)
- H. CA Labor Code §§230 and 230.1 Rights of Victims of Domestic Violence, Sexual Assault, and Stalking

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
11/03/2016	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima 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	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revised	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revised	11/03/2016	GA.8027	Unlawful Harassment	Administrative
Revised	09/06/2018	GA.8027	Unlawful Harassment	Administrative
Revised	06/02/2022	GA.8027	Anti-Harassment	Administrative
Revised	11/02/2023	GA.8027	Harassment, Discrimination and Retaliation Prevention	Administrative
Revised	10/03/2024	GA.8027	Harassment, Discrimination and Retaliation Prevention	Administrative
<u>Revised</u>		<u>GA.8027</u>	<u>Harassment, Discrimination and Retaliation Prevention</u>	<u>Administrative</u>

IX. GLOSSARY

Term	Definition
<u>Credibility</u>	<u>The investigator's evaluation of whether a person's statements made in an investigation are believable, can be relied upon, and are supported by evidence.</u>
Discrimination	Unequal treatment of a person or group on the basis of a protected category.
Employee	Any and all Employees of CalOptima Health, including all permanent and temporary Employees, volunteers, and other employed personnel.
Gender Expression	A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex assigned at birth.
Gender Identity	Each person's internal understanding of their gender, or the perceptions of a person's gender identity, which may include male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.
Harassment	Unwelcome verbal, written or physical conduct that denigrates or shows hostility or aversion toward an individual, based on a protected characteristic, that is so severe or pervasive as to create an intimidating, hostile, or offensive working environment.
Member	<u>An individual</u> enrolled in a CalOptima Health Program.
National Origin	Includes, but is not limited to, the individual's or ancestors' actual or perceived: (1) physical, cultural, or linguistic characteristics associated with a national origin group; (2) marriage to or association with persons of a national origin group; (3) tribal affiliation; (4) membership in or association with an organization identified with or seeking to promote the interests of a national origin group; (5) attendance or participation in schools, churches, temples, mosques, or other religious institutions generally used by persons of a national origin group; (6) name that is associated with a national origin group; and (7) the basis of possessing a driver's license granted under Section 12801.9 of the Vehicle Code.
National Origin Group	Includes, but is not limited to, ethnic groups, geographic places of origin, and countries that are not presently in existence.
<u>Preponderance of the Evidence</u>	<u>Defined by the California Civil Rights Department as the "more likely than not" standard. It requires the investigator to determine whether it is more likely than not that the alleged conduct did or did not occur.</u>
Retaliation	Adverse employment action against an Employee because the Employee filed a complaint or engaged in a protected activity.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth, breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender, gender identity, and gender expression.
Sex Stereotype	Includes, but is not limited to, an assumption about a person's appearance or behavior, gender roles, gender expression, or gender identity, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.
Sexual Harassment	Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions, sex stereotype, gender, gender identity or gender expression) or conduct of a sexual nature.

Term	Definition
Transgender	A general term that refers to a person whose gender identity differs from the person's sex assigned at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as “transsexual.”
Transitioning	A process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may include, but is not limited to, changes in name and pronoun usage, facility usage, participation in employer-sponsored activities (<i>e.g.</i> , sports teams, team-building projects, or volunteering), or undergoing hormone therapy, surgeries, or other medical procedures.

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For 20261001 BOD Review Only



Policy: GA.8027
Title: **Harassment, Discrimination,
and Retaliation Prevention**
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

I. PURPOSE

This policy outlines CalOptima Health's zero tolerance for Discrimination, Harassment, and Retaliation and sets forth a procedure for promptly investigating complaints thereof.

II. POLICY

- A. CalOptima Health is committed to providing a professional work environment that is free of Discrimination and Harassment based on one or more protected category(ies), and an environment free from Retaliation for participating in any protected activity(ies) covered by this policy and CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.
- B. CalOptima Health is committed to providing equal employment opportunities to all Employees and applicants for employment. Accordingly, CalOptima Health has adopted and shall maintain this policy to encourage professional and respectful behavior and prevent discriminating, Harassing, or retaliatory conduct in our workplace. CalOptima Health shall implement appropriate corrective action(s), up to and including termination, in response to any violation of this policy, even if the violation does not rise to the level of unlawful conduct.
- C. CalOptima Health prohibits Discrimination and Harassment based on the following categories: race, color, traits historically associated with race such as hair texture and style, religion, religious creed (including religious observance, dress and grooming practices), national origin, ancestry, citizenship, physical or mental disability, perceived disability, history of disability, medical condition (including cancer and genetic characteristics), genetic information, marital status, registered domestic partner status, sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, gender, transitioning status, gender identity, gender expression, age (40 years and over), sexual orientation, veteran and/or military status, protected medical leaves (requesting or taking leave under the Family and Medical Leave Act or the California Family Rights Act), survivor or family member of a victim of violence and certain crimes, political affiliation, time off work for mandatory jury duty service, perception that anyone has any of those characteristics, association with anyone that has any of those characteristics, and any other status protected by state or federal law. In addition, CalOptima Health prohibits Retaliation against a person who engages reasonably and in good faith in activities protected under this policy in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for

Reporting Violations. Reporting or assisting in reporting suspected violations of this policy and cooperating in investigations or proceedings arising out of an alleged violation of this policy are protected activities.

- D. All Employees are expected to assume responsibility for maintaining a work environment that is free from Discrimination, Harassment and Retaliation. The law prohibits Employees at all levels, as well as third parties with whom CalOptima Health Employees come into contact in the workplace, from engaging in unlawful Discrimination, Harassment and Retaliation. Employees are encouraged to promptly report conduct that they reasonably believe violates this policy so that CalOptima Health shall have an opportunity to address and resolve any concerns. Managers and supervisors are required to promptly report conduct that they believe violates this policy to the Human Resources Department. CalOptima Health is committed to responding to alleged violations of this policy in a timely and fair manner and to taking appropriate action aimed at ending the prohibited conduct.
- E. Complaints/reports under this policy must be based on a reasonable belief of misconduct and made in good faith. CalOptima Health will not tolerate intentional false accusations of Discrimination, Harassment, or Retaliation. The finding of any intentional false accusation is considered a violation of this policy and may result in corrective action up to and including termination.
- F. This policy applies to agents, contractors, volunteers, job applicants, and Employees. In addition, this policy extends to conduct with a connection to an Employee's work, even when the conduct takes place away from CalOptima Health's premises, such as a business trip or business-related social function. Harassment, Discrimination, and/or Retaliation can occur between individuals in different work locations including but not limited to in person, working remotely, on virtual platforms, in messaging apps, and after working hours between personal cell phones. Remote work locations, virtual platforms, social media, and text/email communications are considered part of the workplace for purposes of this policy. CalOptima Health's policy prohibiting Discrimination against CalOptima Health Members is addressed in CalOptima Health Policy HH.1104: Complaints of Discrimination.
- G. CalOptima Health shall take appropriate steps and implement processes to protect Employees from unlawful Discrimination, Harassment and Retaliation in the workplace, including:
1. Employees are encouraged to timely report and file a complaint regarding suspected or actual inappropriate conduct in violation of this policy and/or applicable laws, and, whenever possible, to put the complaint or concern in writing. Employees may designate the report or complaint as confidential, which may remain confidential to the extent possible based on the circumstances and applicable laws, except with respect to the investigation, which may not be completely confidential. Employees can file complaints directly with their immediate supervisor, manager, or the Human Resources Department.
 2. Supervisors and managers are required to forward all complaints, oral and/or written, alleging violation(s) of this policy to the Human Resources Department. Leaders and investigators may not promise absolute confidentiality and must disclose information as needed to conduct a fair investigation.
 3. The Human Resources Department or designee will review any report or complaint of inappropriate conduct in violation of this policy and will complete a timely, thorough, and impartial review and/or investigation, when appropriate, that provides all parties with an opportunity to be heard and reaches reasonable conclusions based on the evidence collected.
 4. Impacted parties are required to reasonably participate in good faith in the review and/or

investigation of complaints alleging inappropriate conduct in violation of this policy.

5. The complainant and respondent will be timely informed of appropriate information related to the progress of the review or investigation, including the findings and closure of an investigation.
 6. If, at the end of the investigation, inappropriate conduct or violation(s) of this policy or applicable law are found, CalOptima Health shall take appropriate remedial measures.
 7. Employees reporting inappropriate conduct, along with Employees participating in the investigation as witnesses, shall not be retaliated against for filing a complaint or participating in the investigation process.
- H. Employees may also file a complaint directly with the United States Equal Employment Opportunity Commission (EEOC) or California Civil Rights Department (CRD) or other appropriate state or federal agency(ies). They may also file a civil action in the appropriate court, subject to applicable laws.
- I. Prohibited Conduct
1. Discrimination: CalOptima Health prohibits Discrimination based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited Discrimination includes unequal treatment based upon the Employee or applicant's association with a member of these protected classes. Discrimination may include but is not necessarily limited to allowing the applicant's or Employee's protected category to be a factor in hiring, promotion, compensation, or other employment related decision, unless otherwise permitted by applicable law; and providing unwarranted assistance or withholding work-related assistance, cooperation, and/or information to applicants or Employees because of their protected category.
 2. Harassment: CalOptima Health prohibits Harassing, disrespectful or unprofessional conduct, including Harassing, disrespectful or unprofessional conduct based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited Harassment can be verbal (such as slurs, jokes, insults, epithets, gestures, or teasing), visual (such as the posting or distribution of offensive posters, symbols, cartoons, drawings, computer displays, or emails), or physical (such as physically threatening another person, blocking someone's way, making physical contact in an unwelcome manner, etc.).
 - a. Sexual Harassment: CalOptima Health prohibits Discrimination and Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, sexual orientation, gender, gender identity, or gender expression. Sexually Harassing conduct need not be motivated by sexual desire and may include situations that began as reciprocal relationships, but that later cease to be reciprocal. Sexual Harassment may involve Harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity. Prohibited Sexual Harassment falls into two categories: (1) "*quid pro quo*" ("this for that") when someone conditions a job, promotion, or other work benefit based on submission to sexual advances or other conduct based on sex; or (2) "hostile work environment" when unwelcome comments or conduct based on sex unreasonably interferes with your work performance or creates an intimidating, hostile, or offensive work environment. Prohibited Sexual Harassment may include all the actions described above as Harassment, as well as other unwelcome sex-based conduct, such as, but not limited to:

- i. Unwelcome or unsolicited sexual advances;
 - ii. Offering employment benefits in exchange for sexual favors;
 - iii. Leering or gestures;
 - iv. Displaying or sharing sexually suggestive objects, pictures, GIFs, cartoons, videos, or posters;
 - v. Derogatory comments, chat messages, epithets, slurs, memes, or jokes;
 - vi. Graphic comments, sexually degrading words, conversations regarding sexual activities, verbal abuse of a sexual nature, or suggestive or obscene messages or invitations;
 - vii. Physical touching or assault, as well as impeding or blocking movements, or other verbal or physical conduct of a sexual nature;
 - viii. Making or threatening retaliatory action after receiving a negative response to a sexual advance;
 - ix. Cyberstalking or repeatedly contacting an Employee online with sexual messages; or
 - x. Sending unwanted messages of a sexual nature through social media if the conduct is connected to the workplace or affects the Employee's work environment.
 - b. Abusive Conduct: CalOptima Health prohibits conduct of an employer or Employee in the workplace, with malice, that a reasonable person would find hostile, offensive, and unrelated to an employer's legitimate business interests. Engaging in a pattern of one or more of the following behaviors meets the definition of abusive conduct under California law. The use of inappropriate language, put-downs, insults and name-calling, taunting, teasing, or making jokes about a co-worker when the intent is to embarrass and humiliate. Sabotaging another Employee's work or copying, plagiarizing, or stealing work from a co-worker and passing it off as one's own.
3. Retaliation: CalOptima Health prohibits Retaliation against an Employee because the Employee has engaged in protected activity. Protected activities may include, but are not limited to, reporting or assisting in reporting suspected violations of this policy, CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations or other applicable laws, and/or cooperating in investigations or proceedings arising out of an alleged violation or other applicable laws. CalOptima Health shall not take any adverse employment action, based on the Employee's protected activity, that materially affects the terms and conditions of the Employee's employment status or is reasonably likely to deter the Employee from engaging in protected activity. Examples of Retaliation under this policy include, but are not limited to: demotion; suspension; reduction in pay; termination; denial of a merit salary increase; failure to hire or consider for hire; refusing to promote or consider for promotion because of reporting a violation of this policy; Harassing another Employee for filing a complaint; denying employment opportunities for making a complaint or cooperating in an investigation; changing someone's work assignments; treating people differently such as denying an accommodation; not talking to an Employee when otherwise required by job duties; or otherwise excluding the Employee from job-related activities because of engagement in activities protected under this policy. Actual or threatened Retaliation for rejecting sexual advances or complaining about Sexual Harassment is also unlawful and a

violation of this policy and CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

J. CalOptima Health shall disseminate this policy to all Employees and require them to acknowledge electronically that each individual has received and understands the policy. All legally required posters shall be posted in a prominent and accessible location in the workplace.

K. Online activities conducted during work hours or for work-related purposes are considered part of the workplace and are subject to the CalOptima Health Harassment, Discrimination, and Retaliation Prevention policy.

L. Training Requirements

1. All non-management/non-supervisory Employees are required to attend Harassment prevention training for Employees (1 hour) within the first six (6) months of hire and at least every two (2) years thereafter.
2. All management/supervisory Employees must complete the Harassment prevention training for leaders (2 hours) within the first six (6) months of hire and at least every two (2) years thereafter. These trainings shall include prevention of abusive conduct in the workplace.

M. Addressing and Reporting Violations

1. Any Employee or applicant who experiences behavior that they believe violates this policy is encouraged to immediately tell the offending individual that the behavior is inappropriate and, if they feel comfortable doing so, to tell the offending individual to stop the behavior.
2. Any Employee witnessing Harassment is encouraged to report it. There are five (5) standard methods of intervention that can be used when anyone witnesses Harassment or Discrimination and wants to help. A witness:
 - a. Can interrupt the Harassment by engaging with the individual being Harassed and distracting them from the Harassing behavior;
 - i. Who feels unsafe interrupting on their own can ask a third party to help intervene in the Harassment;
 - b. Can document the Harassment incident to benefit a future investigation;
 - c. Might check in with the person who has been Harassed after the incident, let them know the behavior was not appropriate, and encourage the person to report it; and/or
 - d. If feeling safe, can advise the harasser that the behavior was inappropriate. Effective intervention focuses on de-escalation through words and non-physical actions.
3. The applicant, witness, or Employee should also immediately report the alleged violation to their supervisor, manager, or the Human Resources Department. They are free to contact the Human Resources Department and are not required to request supervisor or manager approval to do this. If the alleged offender is the Employee's supervisor or manager, the Employee should report the conduct to any other supervisor or manager or the Human Resources Department. A complaint may be brought forward verbally or in writing. Written complaints can be made using, but not limited to, the Employee Complaint Intake Form.

4. Supervisors or managers who learn of any potential violation of this policy are required to immediately report the matter to Human Resources and must follow instructions provided by Human Resources as to how best to proceed.
5. CalOptima Health shall promptly look into the facts and circumstances of any alleged violation, as appropriate. Where the reported behavior does not rise to the level of violating this policy, CalOptima Health may resolve the issue informally, for example, through counseling. If the report contains allegations of conduct that may violate this policy, a formal investigation will be conducted to determine the facts. Even in the absence of a formal complaint, CalOptima Health will initiate an investigation where it has reason to believe that conduct that violates this policy has occurred. Moreover, even where a complainant conveys a request to withdraw their initial complaint, CalOptima Health will continue the investigation to ensure that the workplace is free from Harassment.
6. Anonymous complaints shall also be investigated. The method will depend on the details provided in the anonymous complaint. If the complaint is sufficiently detailed, the investigation may be able to proceed in the same manner as any other complaint. If the information is more general, CalOptima Health may do an environmental assessment or survey to try to determine if misconduct has occurred. All investigations will be fair, impartial, timely, and completed by qualified personnel.
7. To the extent possible, CalOptima Health shall endeavor to keep the applicant or Employee's concerns confidential; however, complete confidentiality cannot be guaranteed when it interferes with CalOptima Health's ability to fulfill its obligations under this policy. All Employees are required to cooperate fully and in good faith with any investigation. This includes, but is not limited to, maintaining an appropriate level of discretion regarding the investigation, and disclosing any and all information that may be pertinent to the investigation. Upon completion of the investigation, if misconduct is substantiated, CalOptima Health shall take appropriate corrective and preventive action calculated to end the conduct up to and including formal corrective action where warranted.

N. Filing of Complaints Outside of CalOptima Health

1. Employees and applicants may file formal complaints of Discrimination, Harassment, or Retaliation with the agencies listed below. Individuals who wish to pursue filing with these agencies should contact them directly to obtain further information about their processes and time limits.
 - a. **California Civil Rights Department**
2218 Kausen Drive Suite 100
Elk Grove CA 95758

800-884-1684 (voice), 800-700-2320 (TTY) or California's Relay Service at 711
contact.center@calcivilrights.ca.gov <https://calcivilrights.ca.gov/>
 - b. **U.S. Equal Employment Opportunity Commission**
450 Golden Gate Avenue 5 West
PO Box 36025
San Francisco CA 94102-3661

1-800-669-4000 or 510-735-8909 (Deaf/hard-of-hearing callers only)
<https://www.eeoc.gov/employees>

- 1 2. Employees or applicants who believe they have been the subject of Discrimination, Harassment
2 or Retaliation for making a complaint or participating in an investigation of Discrimination or
3 Harassment may file a complaint with the CRD within three (3) years of the last act of
4 Discrimination, Harassment or Retaliation. CRD serves as a neutral factfinder and attempts to
5 help the parties voluntarily resolve disputes. CRD may also file a civil complaint and seek court
6 orders changing the employer's policies and practices, and awarding attorney's fees and costs.
7 Employees can also pursue the matter through a private lawsuit in civil court after a complaint
8 has been filed and a Right-to-Sue Notice has been issued.
9

10 **III. PROCEDURE**
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Responsible Party	Action
Employee	- Assume responsibility for a work environment free from Discrimination, Harassment and Retaliation. - Report the facts of any incident(s) of Discrimination or Harassment based on a protected characteristic or Retaliation based on a protected activity immediately to your supervisor, manager, or the Human Resources (HR) Department. - Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation.
Supervisor	- Gather all relevant facts from reporting Employee and report it immediately to the HR Department. - Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation. - Keep reports or complaints of Discrimination, Harassment, or Retaliation confidential, to the extent possible, and follow HR's direction and guidance.

Responsible Party	Action
Human Resources	▪ Upon receipt of a complaint, evaluate the reported misconduct and determine what level of review or investigation is needed and appropriate for the circumstances. ▪ Request supporting documentation and/or additional statements from Employees and potential witnesses, where applicable. ▪ If a determination is made that no further review or investigation is required, a closure notice shall be issued to the complainant documenting the decision. ▪ If a determination is made that an investigation is required, complete an impartial, timely, and thorough investigation of the complaint, which may include interviewing the complaining party, responding party, and relevant witnesses. ▪ Review collected documents, exhibits or other evidence. Analyze the information, make Credibility determinations when needed, reach reasonable conclusions based on the evidence collected, and make findings based on a Preponderance of the Evidence Standard. ▪ If misconduct is found, recommend appropriate remedial measures, along with preventive and/or corrective action, when it is warranted, to department leadership. ▪ Timely inform the complainant of the conclusion of the investigation and any findings. ▪ Timely inform the accused party of the conclusion of the investigation, any findings, and the final decision, if applicable, of remedial measures or preventive and/or corrective action. ▪ HR will strive to maintain confidentiality during the investigation, but there is no guarantee of complete confidentiality. Only the parties who need to know shall be involved.

IV. ATTACHMENT(S)

A. Employee Incident / Complaint Intake Form

V. REFERENCE(S)

- A. CalOptima Health Policy GA.8044: Telework Program
- B. CalOptima Health Policy GA.8062: Social Media Conduct
- C. CalOptima Health Policy HH.1104: Complaints of Discrimination
- D. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
- E. California Government Code, §§12926, 12935, 12940 *et seq.*, 12950, and 12950.1.
- F. Title 2, California Code of Regulations (C.C.R.), §§11008 *et seq.*, 11023, 11027.1(a) and (b), and 1030(a)-(f)
- G. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq.*)
- H. CA Labor Code §§230 and 230.1 Rights of Victims of Domestic Violence, Sexual Assault, and Stalking

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
11/03/2016	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima 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	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revised	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revised	11/03/2016	GA.8027	Unlawful Harassment	Administrative
Revised	09/06/2018	GA.8027	Unlawful Harassment	Administrative
Revised	06/02/2022	GA.8027	Anti-Harassment	Administrative
Revised	11/02/2023	GA.8027	Harassment, Discrimination and Retaliation Prevention	Administrative
Revised	10/03/2024	GA.8027	Harassment, Discrimination and Retaliation Prevention	Administrative
Revised		GA.8027	Harassment, Discrimination and Retaliation Prevention	Administrative

1 IX. GLOSSARY

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Term	Definition
Credibility	The investigator's evaluation of whether a person's statements made in an investigation are believable, can be relied upon, and are supported by evidence.
Discrimination	Unequal treatment of a person or group on the basis of a protected category.
Employee	Any and all Employees of CalOptima Health, including all permanent and temporary Employees, volunteers, and other employed personnel.
Gender Expression	A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex assigned at birth.
Gender Identity	Each person's internal understanding of their gender, or the perceptions of a person's gender identity, which may include male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.
Harassment	Unwelcome verbal, written or physical conduct that denigrates or shows hostility or aversion toward an individual, based on a protected characteristic, that is so severe or pervasive as to create an intimidating, hostile, or offensive working environment.
Member	An individual enrolled in a CalOptima Health Program.
National Origin	Includes, but is not limited to, the individual's or ancestors' actual or perceived: (1) physical, cultural, or linguistic characteristics associated with a national origin group; (2) marriage to or association with persons of a national origin group; (3) tribal affiliation; (4) membership in or association with an organization identified with or seeking to promote the interests of a national origin group; (5) attendance or participation in schools, churches, temples, mosques, or other religious institutions generally used by persons of a national origin group; (6) name that is associated with a national origin group; and (7) the basis of possessing a driver's license granted under Section 12801.9 of the Vehicle Code.
National Origin Group	Includes, but is not limited to, ethnic groups, geographic places of origin, and countries that are not presently in existence.
Preponderance of the Evidence	Defined by the California Civil Rights Department as the "more likely than not" standard. It requires the investigator to determine whether it is more likely than not that the alleged conduct did or did not occur.
Retaliation	Adverse employment action against an Employee because the Employee filed a complaint or engaged in a protected activity.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth, breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender, gender identity, and gender expression.
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Sexual Harassment	Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions, sex stereotype, gender, gender identity or gender expression) or conduct of a sexual nature.

Term	Definition
Transgender	A general term that refers to a person whose gender identity differs from the person's sex assigned at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as “transsexual.”
Transitioning	A process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may include, but is not limited to, changes in name and pronoun usage, facility usage, participation in employer-sponsored activities (<i>e.g.</i> , sports teams, team-building projects, or volunteering), or undergoing hormone therapy, surgeries, or other medical procedures.

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For 20261001 BOD Review Only



HUMAN RESOURCES

EMPLOYEE INCIDENT/ COMPLAINT INTAKE FORM

Employees have the right to file anonymous complaints without fear of punishment or retaliation

First and Last Name:		Today's Date:	
Department:		Contact #:	
Job Title:		Contact Email:	
Employee ID#:		Supervisor's Name:	

Complete all fields to the extent possible, sign, and submit it with any Attachments to Human Resources Employee Relations at employeerelations@caloptima.org.

WHAT IS THE SPECIFIC SITUATION(S) THAT BROUGHT YOU TO CONTACT HUMAN RESOURCES THAT YOU ARE REPORTING FOR REVIEW TODAY? PLEASE

1. INCLUDE INCIDENT AND DATE, TIME AND LOCATION:

2. PROVIDE THE NAMES(S) AND POSITIONS OF EVERYONE EMPLOYEE(S) CONTRIBUTING OR INVOLVED IN THE REPORTED INCIDENT AND THEIR RELATIONSHIP TO THE COMPLAINT YOU:

3. GIVE SPECIFIC EXAMPLES OF THEIR BEHAVIOR/ACTIONS AND ANY INFORMATION OR BELIEF AS TO WHAT MOTIVATED ANY OF THESE ACTIONS. PLEASE INCLUDE DATES, TIMES, AND LOCATION:

4. IDENTIFY THOSE WHO MAY HAVE WITNESSED OR HAVE KNOWLEDGE OF THE INCIDENTS. PLEASE PROVIDE NAMES, ~~(S)~~ AND POSITIONS, ~~OF EMPLOYEE AND NON-EMPLOYEE AND CURRENT RELATIONSHIP, IF APPLICAB,~~ WHERE APPLICABLE. ~~FOR NON-EMPLOYEES INDICATE RELATIONSHIP AND CONTACT INFORMATION IF AVAILABLE:~~

5. PROVIDE Do you HAVE ANY RELEVANT DOCUMENTS OR OTHER EVIDENCE TO SUPPORT YOUR COMPLAINTECLAIM. (S)? IF YES, PLEASE LIST THEM HERE AND ~~ATTACH~~ INCLUDE COPIES WITH THIS FORM SUBMISSION.

HAVE YOU REPORTED THIS COMPLAINT TO YOUR DEPARTMENT LEADERSHIP? IF SO, DESCRIBE ANY EFFORTS TO INFORMALLY RESOLVE YOUR COMPLAINT? IF SO, WHAT WAS THE OUTCOME?

6. PLEASE EXPLAIN IN DETAIL, INCLUDING DATES AND TIMES AND OUTCOMES.



7. ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE? WHAT REMEDY OUTCOME DO YOU EXPECT REQUEST FROM FILING THIS PROCESS YOUR COMPLAINT? PROVIDE ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE.

Employees submitting a complaint to Human Resources are protected from retaliation under policy GA.8027 Harassment, Discrimination, and Retaliation Prevention.

EMPLOYEE SIGNATURE: _____

TYPE-WRITTEN "SIGNATURE" ACCEPTED WHEN SUBMITTING FROM YOUR CALOPTIMA HEALTH EMAIL:

DATE:

Please submit this form for review to: employeerelations@caloptima.org



Policy: GA.8036
Title: **Education Reimbursement**
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

I. PURPOSE

This policy describes CalOptima Health's pre-approval process for the educational reimbursement program established to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements.

II. POLICY

A. CalOptima Health encourages employees to further and enhance their professional skills and knowledge through continued education in areas that will contribute to the improvement of their present job function, or potential advancement to other positions at CalOptima Health.

A.B. Regular Full-Time Employees and regular Part-Time Employees who have completed their initial one-hundred-eighty (180) calendar days of continuous employment, and are in Good Standing, are eligible to participate.

1. Good Standing is verified both at the time of initial request and prior to employee reimbursement.

B.C. Courses and degree programs eligible for education reimbursement must be either part of an accredited college, or provided by credible institutions that meet the following conditions:

1. Educate the employee in concepts and methods in their present assignment;
2. Help prepare the employee for advancement to other positions available within CalOptima Health; and/or
3. Earn continuing education credits (CEC) towards maintaining a current credential that is required or preferred in their current position or in potential advancement.

D. Related activities or supplementary items that are ineligible for education reimbursement include:

1. Seminars, conferences, or other business meetings that do not result in an eligible certification or CEC.
2. Courses, or other programs, involving sports, games, or hobbies.

3. License or certification examination fees and renewal fees of licensures or certifications.

1.4. Books, stationery, parking, food, travel, education subscriptions, and other miscellaneous fees or expenses are not covered under this policy.

~~C.E.~~ CalOptima Health will reimburse eligible Full-Time Employees for qualifying courses up to five thousand two hundred fifty dollars (\$5,250.00) per fiscal year for tuition expenses only. CalOptima Health will reimburse eligible Part-Time Employees for qualifying courses up to two thousand six hundred dollars (\$2,600.00) per fiscal year for tuition expenses only. Reimbursement will not be made until the employee has successfully completed the course with a grade of "C" or better for undergraduate and graduate programs, a "Pass" for courses that are Pass/Fail, or a certificate of successful completion. Employees must still be employed at CalOptima Health upon completing the course or program and when they submit their request for reimbursement to qualify for reimbursement.

1. According to current Internal Revenue Service (IRS) guidelines, reimbursement of up to five thousand two hundred fifty dollars (\$5,250.00) per calendar year is not considered to be taxable earnings. Reimbursement that exceeds IRS Guidelines for a specific calendar year is considered taxable earnings and is subject to federal and state income and payroll tax withholdings in accordance with federal and state law. Employees are responsible for any tax liability arising from the receipt of education reimbursement under this policy.

F. This policy is not intended to prohibit department leaders from budgeting or paying for the seminars, business meetings, or examination and renewal costs of the licensures or certifications of their staff at their discretion.

G. An employee must submit the completed reimbursement request form to Human Resources prior to the start of the requested course to be eligible for reimbursement. To avoid processing delays, it is recommended that forms be submitted at least three (3) weeks prior to the start of the requested course.

1. Forms received late solely as a result of delayed department approval will not be considered late for the purposes of the policy.
2. In the event of a delayed department approval, employees must notify Human Resources prior to the start of course.

~~D.H.~~ Employees are required to manage time for classes outside of scheduled hours and classes must not interfere with their regular job duties.

~~E.I.~~ Education reimbursement requests are processed on a first-come, first-served basis, The annual maximum employee benefit for education reimbursement is calculated for each fiscal year (July 1 – June 30) based on the course end date.

III. PROCEDURE

Responsible Party	Action
Employee	1. Complete the Request for Education Expense Reimbursement form <u>for submission</u> prior to start of the course or certification. a. <u>To avoid processing delays, forms should be submitted as soon as feasible and preferably</u> no less than three weeks prior.

Responsible Party	Action
	b. Forms submitted to supervisor after the start of the course will be denied for late submission. 2. Obtain approval from direct supervisor and Director, or Chief, and submit completed <u>forms</u> to HR. 3. Obtain notification from HR of preliminary approval, or denial, of request. a. Request form MUST be received prior to the start of the course in order to be considered. i. Forms received late <u>solely</u> as a result of delayed department approval will not be considered late for the purposes of <u>the</u> policy. <u>ii. In the event of a delayed department approval, employees must notify Human Resources prior to the start of course.</u> b. <u>Applicants</u> should allow sufficient time for review and preliminary approval prior to start of course or enroll with the understanding <u>the request</u> may not be approved by HR. 4. Within sixty (60) calendar days of course completion, submit: a. Proof of completion: For courses taken at a college or university, proof requires official documentation from the school (examples: a transcript/grade report from the Registrar's office or full document downloaded from the student portal). For all other courses, <u>the employee may submit an</u> official notification showing grades for each course, a copy of the certificate of completion, or certification. b. Proof of cost of tuition: This includes tuition fees or costs from the college, university, institution, or certifying board. Proof of payment: This may be a canceled check, credit card receipt, cash receipt, or other document that clearly demonstrates the method of payment made by the employee. For courses taken at a college or university, proof also requires payment confirmation to the institution (examples: payment records from the Bursars/Finance Office or downloaded account documentation from the student portal). c. Additional documentation may be requested to verify eligibility.
Supervisor (<u>direct leader</u>)	<u>1. Review according to policy guidelines and timelines.</u> 1.<u>2.</u> Provide statement on the form to confirm applicability of course and benefit to CalOptima Health. 2.<u>3.</u> Certify <u>the</u> employee has completed at least one hundred eighty (180) days of continuing employment as a Full-Time or Part-Time Employee, is in Good Standing with CalOptima Health, and will complete the education outside scheduled hours.

Responsible Party	Action
	3.4. Approve, or deny, request <u>in a timely manner</u>. 4.5. Forward to Director, or Chief <u>for second leader approval</u>
Director/Chief (second leader approval)	<u>1. Review according to policy guidelines and timelines.</u> 4.2. Approve, or deny, request <u>in a timely manner</u>. <u>2.3. Return completed form to the employee to submit</u> to HR.
Human Resources	1. Evaluate <u>requests</u> for compliance with this policy, and if applicable, provide preliminary approval. 2. Notify the employee if the request is <u>pre</u>-approved or denied. 3. Hold form until proof of completion is submitted. 4. Upon verification of satisfactory completion consistent with this policy, follow Accounting current procedures for approval and payment of reimbursement.
Accounting	1. Issue reimbursement payment according to IRS guidelines.

IV. ATTACHMENT(S)

Not applicable

V. REFERENCE(S)

- A. CalOptima Health Policy GA.8033: License and Certification Tracking
- B. Title 26, United States Code, §127
- C. Education Expense Reimbursement Prior Authorization Request

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/05/2012	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
10/03/2024	Regular Meeting of the CalOptima Health Board of Directors

1 **VIII. REVISION HISTORY**

2

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8036	Education Reimbursement	Administrative
Revised	06/04/2015	GA.8036	Education Reimbursement	Administrative
Revised	02/02/2017	GA.8036	Education Reimbursement	Administrative
Revised	02/07/2019	GA.8036	Education Reimbursement	Administrative
Revised	12/20/2021	GA.8036	Education Reimbursement	Administrative
Revised	06/02/2022	GA.8036	Education Reimbursement	Administrative
Revised	10/03/2024	GA.8036	Education Reimbursement	Administrative
<u>Revised</u>		<u>GA.8036</u>	<u>Education Reimbursement</u>	<u>Administrative</u>

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For 20261001 BOD Review Only

1 IX. GLOSSARY

2

Term	Definition
<u>Accredited College</u>	<u>Institution, college, or university accredited by a state, federal, or non-governmental coordinating agency such as the Higher Learning Commission (HLC) or the Western Association of Schools and College – Senior College and University Commission (WSCUC).</u>
<u>Continuing education credits (CEC)</u>	<u>Numerical credits assigned to professional training courses, usually on the basis of completion hours used to measure and assign units to licenses or certifications that require those credits for renewal.</u>
<u>Creditable Institution</u>	<u>Professional organizations, academies, trade groups, and associations that have either formal accreditation such as from the International Accreditors for Continuing Education and Training (IACET) or similar industry recognition as subject matter experts.</u>
Full-Time Employees	An employee who works sixty (60) to eighty (80) hours per pay period.
Good Standing	The employee has at least <u>an overall meets expectation</u> level of performance on their most recent evaluation and has not received <u>formal</u> written corrective action within the last six (6) months.
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

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Policy: GA.8036
Title: **Education Reimbursement**
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

I. PURPOSE

This policy describes CalOptima Health's pre-approval process for the educational reimbursement program established to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements.

II. POLICY

- A. CalOptima Health encourages employees to further and enhance their professional skills and knowledge through continued education in areas that will contribute to the improvement of their present job function, or potential advancement to other positions at CalOptima Health.
- B. Regular Full-Time Employees and regular Part-Time Employees who have completed their initial one-hundred-eighty (180) calendar days of continuous employment, and are in Good Standing, are eligible to participate.
 1. Good Standing is verified both at the time of initial request and prior to employee reimbursement.
- C. Courses and degree programs eligible for education reimbursement must be either part of an accredited college, or provided by credible institutions that meet the following conditions:
 1. Educate the employee in concepts and methods in their present assignment;
 2. Help prepare the employee for advancement to other positions available within CalOptima Health; and/or
 3. Earn continuing education credits (CEC) towards maintaining a current credential that is required or preferred in their current position or in potential advancement.
- D. Related activities or supplementary items that are ineligible for education reimbursement include:
 1. Seminars, conferences, or other business meetings that do not result in an eligible certification or CEC.
 2. Courses, or other programs, involving sports, games, or hobbies.

3. License or certification examination fees and renewal fees of licensures or certifications.
 4. Books, stationery, parking, food, travel, education subscriptions, and other miscellaneous fees or expenses are not covered under this policy.
- E. CalOptima Health will reimburse eligible Full-Time Employees for qualifying courses up to five thousand two hundred fifty dollars (\$5,250.00) per fiscal year for tuition expenses only. CalOptima Health will reimburse eligible Part-Time Employees for qualifying courses up to two thousand six hundred dollars (\$2,600.00) per fiscal year for tuition expenses only. Reimbursement will not be made until the employee has successfully completed the course with a grade of “C” or better for undergraduate and graduate programs, a “Pass” for courses that are Pass/Fail, or a certificate of successful completion. Employees must still be employed at CalOptima Health upon completing the course or program and when they submit their request for reimbursement to qualify for reimbursement.
1. According to current Internal Revenue Service (IRS) guidelines, reimbursement of up to five thousand two hundred fifty dollars (\$5,250.00) per calendar year is not considered to be taxable earnings. Reimbursement that exceeds IRS Guidelines for a specific calendar year is considered taxable earnings and is subject to federal and state income and payroll tax withholdings in accordance with federal and state law. Employees are responsible for any tax liability arising from the receipt of education reimbursement under this policy.
- F. This policy is not intended to prohibit department leaders from budgeting or paying for the seminars, business meetings, or examination and renewal costs of the licensures or certifications of their staff at their discretion.
- G. An employee must submit the completed reimbursement request form to Human Resources prior to the start of the requested course to be eligible for reimbursement. To avoid processing delays, it is recommended that forms be submitted at least three (3) weeks prior to the start of the requested course.
1. Forms received late solely as a result of delayed department approval will not be considered late for the purposes of the policy.
 2. In the event of a delayed department approval, employees must notify Human Resources prior to the start of course.
- H. Employees are required to manage time for classes outside of scheduled hours and classes must not interfere with their regular job duties.
- I. Education reimbursement requests are processed on a first-come, first-served basis. The annual maximum employee benefit for education reimbursement is calculated for each fiscal year (July 1 – June 30) based on the course end date.

III. PROCEDURE

Responsible Party	Action
Employee	1. Complete the Request for Education Expense Reimbursement form for submission prior to start of the course or certification. a. To avoid processing delays, forms should be submitted as soon as feasible and preferably no less than three weeks prior.

Responsible Party	Action
	b. Forms submitted to supervisor after the start of the course will be denied for late submission. 2. Obtain approval from direct supervisor and Director, or Chief, and submit completed forms to HR. 3. Obtain notification from HR of preliminary approval, or denial, of request. a. Request form MUST be received prior to the start of the course in order to be considered. i. Forms received late solely as a result of delayed department approval will not be considered late for the purposes of the policy. ii. In the event of a delayed department approval, employees must notify Human Resources prior to the start of course. b. Applicants should allow sufficient time for review and preliminary approval prior to start of course or enroll with the understanding the request may not be approved by HR. 4. Within sixty (60) calendar days of course completion, submit: a. Proof of completion: For courses taken at a college or university, proof requires official documentation from the school (examples: a transcript/grade report from the Registrar's office or full document downloaded from the student portal). For all other courses, the employee may submit an official notification showing grades for each course, a copy of the certificate of completion, or certification. b. Proof of cost of tuition: This includes tuition fees or costs from the college, university, institution, or certifying board. Proof of payment: This may be a canceled check, credit card receipt, cash receipt, or other document that clearly demonstrates the method of payment made by the employee. For courses taken at a college or university, proof also requires payment confirmation to the institution (examples: payment records from the Bursars/Finance Office or downloaded account documentation from the student portal). c. Additional documentation may be requested to verify eligibility.
Supervisor (direct leader)	1. Review according to policy guidelines and timelines. 2. Provide statement on the form to confirm applicability of course and benefit to CalOptima Health. 3. Certify the employee has completed at least one hundred eighty (180) days of continuing employment as a Full-Time or Part-Time Employee, is in Good Standing with CalOptima Health, and will complete the education outside scheduled hours.

Responsible Party	Action
	4. Approve, or deny, request in a timely manner. 5. Forward to Director, or Chief for second leader approval
Director/Chief (second leader approval)	1. Review according to policy guidelines and timelines. 2. Approve, or deny, request in a timely manner. 3. Return completed form to the employee to submit to HR.
Human Resources	1. Evaluate requests for compliance with this policy, and if applicable, provide preliminary approval. 2. Notify the employee if the request is pre-approved or denied. 3. Hold form until proof of completion is submitted. 4. Upon verification of satisfactory completion consistent with this policy, follow Accounting current procedures for approval and payment of reimbursement.
Accounting	1. Issue reimbursement payment according to IRS guidelines.

IV. ATTACHMENT(S)

Not applicable

V. REFERENCE(S)

- A. CalOptima Health Policy GA.8033: License and Certification Tracking
- B. Title 26, United States Code, §127
- C. Education Expense Reimbursement Prior Authorization Request

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/05/2012	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
10/03/2024	Regular Meeting of the CalOptima Health Board of Directors

1 **VIII. REVISION HISTORY**

2

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8036	Education Reimbursement	Administrative
Revised	06/04/2015	GA.8036	Education Reimbursement	Administrative
Revised	02/02/2017	GA.8036	Education Reimbursement	Administrative
Revised	02/07/2019	GA.8036	Education Reimbursement	Administrative
Revised	12/20/2021	GA.8036	Education Reimbursement	Administrative
Revised	06/02/2022	GA.8036	Education Reimbursement	Administrative
Revised	10/03/2024	GA.8036	Education Reimbursement	Administrative
Revised		GA.8036	Education Reimbursement	Administrative

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For 20261001 BOD Review Only

1 IX. GLOSSARY
2

Term	Definition
Accredited College	Institution, college, or university accredited by a state, federal, or non-governmental coordinating agency such as the Higher Learning Commission (HLC) or the Western Association of Schools and College – Senior College and University Commission (WSCUC).
Continuing education credits (CEC)	Numerical credits assigned to professional training courses, usually on the basis of completion hours used to measure and assign units to licenses or certifications that require those credits for renewal.
Creditable Institution	Professional organizations, academies, trade groups, and associations that have either formal accreditation such as from the International Accreditors for Continuing Education and Training (IACET) or similar industry recognition as subject matter experts.
Full-Time Employees	An employee who works sixty (60) to eighty (80) hours per pay period.
Good Standing	The employee has at least an overall meets expectation level of performance on their most recent evaluation and has not received formal written corrective action within the last six (6) months.
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

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Policy: GA.8050
Title: **Confidentiality**
Department: Human Resources
Section: Not Applicable

CEO Approval: /s/

Effective Date: 02/01/2014

Revised Date:

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

I. PURPOSE

This policy outlines CalOptima Health's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Health Board members, executive staff, employees, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima Health to any person, including, but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima Health has authorized disclosure in writing. This obligation includes making sure proprietary, private, and/or confidential information is secure (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.

B. Proprietary information is all information owned by CalOptima Health, obtained, or created by Employees during the course of their work with or at CalOptima Health, including, but not limited to, intellectual property, computer software, and provider identification numbers.

C. Private information is any personal information for which an individual, group, or entity would reasonably expect to be restricted from public access, including, but not limited to, any information related to a person's health, member file, personnel file, recruitment and application records, workers' compensation file, date of birth, and social security number.

B.D. Confidential information is any information that is not known generally to the public and is accessible only to those for whom it is intended or directed, including, but not limited to, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, Protected Health Information (PHI), Personally Identifiable Information (PII), procurement requests, vendor proposals or bids, contracts, administrative files, computer records, computer programs, and financial data. Information may be one or more of proprietary, private, and/or confidential in nature.

~~C.E.~~ Inappropriate use, unauthorized copy or transfer, attempted destruction, or the destruction or disclosure of proprietary, private, and/or confidential information obtained through the Employee's

affiliation with CalOptima Health will subject an Employee to corrective action, up to and including termination, and possible legal recourse.

III. PROCEDURE

A. Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee or Employee of CalOptima Health;
2. Exercise good judgment and care at all times to avoid unauthorized or improper disclosures of proprietary, private, and/or confidential information; and
3. Adhere to all CalOptima Health compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, including, but not limited to, CalOptima Health Policies, GA.5005a: Acceptable Use of Technology Resources, HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls, HH.3011: Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations, HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI), ITS.1201: Technical Safeguards - Access Controls, ITS.1202: Technical Safeguards - Data Controls, and ITS.1301: Security Awareness Training.
4. Employees are expected to report confidentiality issues under this policy and can do so anonymously to the Compliance and Ethics hotline at 1-855-507-1805.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss proprietary, private, and/or confidential information if the conversation could be heard by unauthorized persons.

C. Consistent with California Penal Code Section 632, Employees may not secretly record or capture audio, video, or transcription of virtual or in-person workplace conversations or meetings.

1. Training sessions, educational presentations, or other types of special meetings may be recorded by the meeting organizer after notice is provided to all participants.
2. Closed-captioning features may only be used for accessibility and legitimate business purposes.
3. Authorized recordings may be considered public records. They must be created and stored on agency devices and systems subject to AA.1215 Public Records Requests and Subpoenas.
4. Employees are prohibited from recording workplace meetings and conversations on personal devices or storage systems.

~~C.D.~~ Employees may be subject to more specific legal, regulatory, and contractual requirements regarding proprietary, private, and/or confidential information. In brief summary, Employees and individuals affiliated with CalOptima Health are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by state and federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.
2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima Health's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any information obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.
3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.
4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality provisions, e.g., minors, victims of abuse.
5. Rates: The rates paid to CalOptima Health by the Department of Health Care Services (DHCS) and the rates CalOptima Health pays to its contractors/providers are confidential under state and federal law.

~~D.E.~~ HIPAA requires CalOptima Health, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima Health is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima Health policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member, or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.
2. Unacceptable Use: PHI shall not be used for personal benefit or for the benefit of any other person or entity. Divulging the Medi-Cal status or other PHI of a Member to unauthorized recipients is prohibited.
3. Privacy and Security Safeguards: CalOptima Health is required to have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI. These safeguards may include, but are not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

~~E.F.~~ At the end of a Board member's term in office, or upon the termination of an Employee's relationship with CalOptima Health, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from proprietary, private and/or confidential information in his or her possession.

~~F.G.~~ Any individual covered by this policy who violates its provisions shall be subject to corrective action up to and including separation from service or affiliation with CalOptima Health, as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of proprietary, private, and/or confidential information after leaving affiliation with CalOptima Health.

~~G.H.~~ CalOptima Health shall provide new hires with this policy.

1. All Employees are required to sign an acknowledgment that they have received and read, and understand, this policy and agree to comply with it.
2. Failure to sign such acknowledgment may result in corrective action up to and including termination.

~~H.I.~~ CalOptima Health welcomes new ideas related to the security of our proprietary, private, and/or confidential information and encourages Employees to share them with their supervisors and managers to continually improve existing practices. If any Employee would like to remain anonymous when sharing such ideas, that Employee may contact the Human Resources Employee Relations unit.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct

B. CalOptima Health Compliance Plan

~~C.~~ CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas

~~C.D.~~ CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources

~~D.E.~~ CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls

~~E.F.~~ CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations

~~F.G.~~ CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)

~~G.H.~~ CalOptima Health Policy ITS.1201: Technical Safeguards - Access Controls

~~H.I.~~ CalOptima Health Policy ITS.1202: Technical Safeguards - Data Controls

~~I.J.~~ CalOptima Health Policy ITS.1301: Security Awareness Training

~~J.K.~~ Confidentiality Statement

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Regulatory Agency
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative
Revised	10/04/2018	GA.8050	Confidentiality	Administrative
Revised	06/02/2022	GA.8050	Confidentiality	Administrative
Revised	06/06/2024	GA.8050	Confidentiality	Administrative
<u>Revised</u>		<u>GA.8050</u>	<u>Confidentiality</u>	<u>Administrative</u>

1 IX. GLOSSARY
2

Term	Definition
Covered Services	<u>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.</u> <u>Medi-Cal:</u> 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. <u>PACE</u>: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise
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	specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Employee	For purposes of this policy, CalOptima Health Board members, executive staff, employees, contractors, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents.
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.
Medical Record	<u>Medi-Cal & Covered California: 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.</u> <u>OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.</u>
Member	<u>An individual enrolled in a CalOptima Health program.</u>
<u>Personally Identifiable Information (PII)</u>	<u>Information that can distinguish or trace an individual's identity such as name, email address, Social Security number, date of birth, financial information, educational information, employment information, and other linked information such as medical history.</u>
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.

Provider	<u>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.</u> <u>Med-Cal:</u> 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. <u>OneCare:</u> 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.
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Policy: GA.8050
Title: **Confidentiality**
Department: Human Resources
Section: Not Applicable

CEO Approval: /s/

Effective Date: 02/01/2014

Revised Date:

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

I. PURPOSE

This policy outlines CalOptima Health's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

- A. CalOptima Health Board members, executive staff, employees, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima Health to any person, including, but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima Health has authorized disclosure in writing. This obligation includes making sure proprietary, private, and/or confidential information is secure (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.
- B. Proprietary information is all information owned by CalOptima Health, obtained, or created by Employees during the course of their work with or at CalOptima Health, including, but not limited to, intellectual property, computer software, and provider identification numbers.
- C. Private information is any personal information for which an individual, group, or entity would reasonably expect to be restricted from public access, including, but not limited to, any information related to a person's health, member file, personnel file, recruitment and application records, workers' compensation file, date of birth, and social security number.
- D. Confidential information is any information that is not known generally to the public and is accessible only to those for whom it is intended or directed, including, but not limited to, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, Protected Health Information (PHI), Personally Identifiable Information (PII), procurement requests, vendor proposals or bids, contracts, administrative files, computer records, computer programs, and financial data. Information may be one or more of proprietary, private, and/or confidential in nature.
- E. Inappropriate use, unauthorized copy or transfer, attempted destruction, or the destruction or disclosure of proprietary, private, and/or confidential information obtained through the Employee's

affiliation with CalOptima Health will subject an Employee to corrective action, up to and including termination, and possible legal recourse.

III. PROCEDURE

A. Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee or Employee of CalOptima Health;
2. Exercise good judgment and care at all times to avoid unauthorized or improper disclosures of proprietary, private, and/or confidential information; and
3. Adhere to all CalOptima Health compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, including, but not limited to, CalOptima Health Policies, GA.5005a: Acceptable Use of Technology Resources, HH.3002: Minimum Necessary Uses and Disclosures of Protected Health Information and Document Controls, HH.3011: Use and Disclosure of Protected Health Information for Treatment, Payment, and Health Care Operations, HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI), ITS.1201: Technical Safeguards - Access Controls, ITS.1202: Technical Safeguards - Data Controls, and ITS.1301: Security Awareness Training.
4. Employees are expected to report confidentiality issues under this policy and can do so anonymously to the Compliance and Ethics hotline at 1-855-507-1805.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss proprietary, private, and/or confidential information if the conversation could be heard by unauthorized persons.

C. Consistent with California Penal Code Section 632, Employees may not secretly record or capture audio, video, or transcription of virtual or in-person workplace conversations or meetings.

1. Training sessions, educational presentations, or other types of special meetings may be recorded by the meeting organizer after notice is provided to all participants.
2. Closed-captioning features may only be used for accessibility and legitimate business purposes.
3. Authorized recordings may be considered public records. They must be created and stored on agency devices and systems subject to AA.1215 Public Records Requests and Subpoenas.
4. Employees are prohibited from recording workplace meetings and conversations on personal devices or storage systems.

1 D. Employees may be subject to more specific legal, regulatory, and contractual requirements
2 regarding proprietary, private, and/or confidential information. In brief summary, Employees and
3 individuals affiliated with CalOptima Health are subject to various confidentiality provisions such
4 as:

- 5
6 1. Public Assistance Recipients: The identity of an individual receiving public services/assistance
7 is protected by state and federal law. Medi-Cal is a form of public assistance and providing
8 information regarding an individual's eligibility is limited only to purposes of service delivery.
9 Only those designated individuals responsible for verifying eligibility to providers should be
10 providing such information and only to authorized recipients.
11
- 12 2. Medical Records: Medical condition and treatment records are confidential between the treating
13 healthcare Provider and Member. Such information is protected under California and federal
14 law. When authorized, such records may be subject to review by qualified professionals
15 involved in CalOptima Health's responsibilities related to such functions as claims, utilization
16 review, quality assurance, grievance appeals, etc. Any information obtained in this regard must
17 be kept confidential and may not be disclosed to unauthorized persons.
18
- 19 3. Special Health Conditions: Information related to the identity of individuals receiving treatment
20 with certain health conditions carry further confidentiality protection, e.g., AIDS, substance
21 abuse, mental illness, or venereal disease.
22
- 23 4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality
24 provisions, e.g., minors, victims of abuse.
25
- 26 5. Rates: The rates paid to CalOptima Health by the Department of Health Care Services (DHCS)
27 and the rates CalOptima Health pays to its contractors/providers are confidential under state and
28 federal law.
29

30 E. HIPAA requires CalOptima Health, its Employees, and its agents to comply with the following
31 standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health
32 information, including demographic information. CalOptima Health is committed to ensuring the
33 privacy and security of Member information, and Employees shall comply with applicable laws and
34 CalOptima Health policies and procedures to protect and maintain the confidentiality of PHI as
35 outlined below:

- 36
37 1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or
38 services for the purpose of treatment, payment, or health care operations, unless otherwise
39 authorized by the Member, or required by law. In addition, use or disclosure of PHI should be
40 limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or
41 request.
42
- 43 2. Unacceptable Use: PHI shall not be used for personal benefit or for the benefit of any other
44 person or entity. Divulging the Medi-Cal status or other PHI of a Member to unauthorized
45 recipients is prohibited.
46
- 47 3. Privacy and Security Safeguards: CalOptima Health is required to have in place administrative,
48 physical, and technical safeguards that reasonably and appropriately protect the confidentiality,
49 integrity, and availability of PHI. These safeguards may include, but are not limited to,
50 physically securing PHI in paper form and encrypting PHI in electronic form.
51

- 1 F. At the end of a Board member's term in office, or upon the termination of an Employee's
2 relationship with CalOptima Health, he or she shall immediately return all documents, papers,
3 electronic files, and other materials, regardless of medium, which may contain or be derived from
4 proprietary, private and/or confidential information in his or her possession.
5
6 G. Any individual covered by this policy who violates its provisions shall be subject to corrective
7 action up to and including separation from service or affiliation with CalOptima Health, as well as
8 possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure
9 or use of proprietary, private, and/or confidential information after leaving affiliation with
10 CalOptima Health.
11
12 H. CalOptima Health shall provide new hires with this policy.
13
14 1. All Employees are required to sign an acknowledgment that they have received and read, and
15 understand, this policy and agree to comply with it.
16
17 2. Failure to sign such acknowledgment may result in corrective action up to and including
18 termination.
19
20 I. CalOptima Health welcomes new ideas related to the security of our proprietary, private, and/or
21 confidential information and encourages Employees to share them with their supervisors and
22 managers to continually improve existing practices. If any Employee would like to remain
23 anonymous when sharing such ideas, that Employee may contact the Human Resources Employee
24 Relations unit.
25

26 **IV. ATTACHMENT(S)**

27 Not Applicable
28
29

30 **V. REFERENCE(S)**

- 31
32 A. CalOptima Health Code of Conduct
33 B. CalOptima Health Compliance Plan
34 C. CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas
35 D. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
36 E. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosures of Protected Health
37 Information and Document Controls
38 F. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information for
39 Treatment, Payment, and Health Care Operations
40 G. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected
41 Health Information (PHI)
42 H. CalOptima Health Policy ITS.1201: Technical Safeguards - Access Controls
43 I. CalOptima Health Policy ITS.1202: Technical Safeguards - Data Controls
44 J. CalOptima Health Policy ITS.1301: Security Awareness Training
45 K. Confidentiality Statement
46

47 **VI. REGULATORY AGENCY APPROVAL(S)**

48 None to Date
49
50

51 **VII. BOARD ACTION(S)**

Date	Regulatory Agency
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors
06/06/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative
Revised	10/04/2018	GA.8050	Confidentiality	Administrative
Revised	06/02/2022	GA.8050	Confidentiality	Administrative
Revised	06/06/2024	GA.8050	Confidentiality	Administrative
Revised		GA.8050	Confidentiality	Administrative

1 IX. GLOSSARY
2

Term	Definition
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. <u>Medi-Cal</u>: 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal 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 the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III,

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Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Med-Cal</u>: 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. <u>OneCare</u>: 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.
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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve CalOptima Health Pharmacy Management Policies Related to Covered California

Contact

Dr. Zeinab Dabbah, Deputy Chief Medical Officer, (714) 246-8491

Recommended Action

Approve pharmacy management policies and procedures to reflect new operational requirements for CalOptima Health's Covered California product, effective January 1, 2027:

1. CalOptima Health Policy CC.1903: Physician Administered Drug (PAD) Prior Authorization Process; and
2. CalOptima Health Policy CC.1904: Notification Regarding Medication Recalls.

Background

Over the past two years, CalOptima Health has made significant progress preparing for entrance into the Covered California program. The CalOptima Health Board of Directors (Board) has taken several actions related to Covered California. On August 1, 2024, the Board authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California.

On August 6, 2026, the Board authorized CalOptima Health to execute the Qualified Health Plan contract with Covered California. On August 11, 2026, CalOptima Health received conditional approval from the Department of Managed Health Care (DMHC) to expand the scope of its current Knox-Keene Act license to enable CalOptima Health to offer the Covered California product.

Discussion

On June 5, 2025, the Board approved several CalOptima Health policies related to regulatory requirements for Covered California as part of the DMHC filing process. The process required the

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

In addition to regulatory policies approved by DMHC, staff evaluated several operational policies and procedures, determining that a policy change or update was necessary to address operational changes for CalOptima Health's Covered California product. While these policy updates currently do not require DMHC approval, they are required to support the implementation of CalOptima Health's Covered California product.

In the area of pharmacy management, staff recommends approval of two (2) new policies for CalOptima Health's Covered California product as outlined in the table below:

Policies & Procedures Summary – Pharmacy Management

<i>Policy</i>	<i>Summary of Change/Update</i>
CalOptima Health Policy CC.1903: Physician Administered Drug (PAD) Prior Authorization Process	New policy defines CalOptima Health's development and management process of the delegated health network PAD prior authorization list for its Covered California product.
CalOptima Health Policy CC.1904: Notification Regarding Medication Recalls	New policy defines the process by which CalOptima Health notifies members or member's authorized representatives and prescribers of medication recalls and market withdrawals for its Covered California product.

Staff seeks Board approval of the attached new policies, effective January 1, 2027.

Fiscal Impact

The recommended action to approve these new policies 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

Approval of new policies and procedures related to pharmacy management will support CalOptima Health's operational implementation of its Covered California product.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy CC.1903: Physician Administered Drug (PAD) Prior Authorization Process
2. CalOptima Health Policy CC.1904: Notification Regarding Medication Recalls

Policy: CC.1903
Title: **Physician Administered Drug (PAD) Prior Authorization Process**
Department: Pharmacy Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2027
Revised Date: Not Applicable

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☐ Medi-Cal
☐ OneCare
☒ PACE

I. PURPOSE

This policy defines CalOptima Health and its delegated Health Networks Physician Administered Drug (PAD) Prior Authorization (PA) list development and management process.

II. POLICY

A. The Physician Administered Drug (PAD) Prior Authorization (PA) List development and management process shall ensure Member access to clinically appropriate and cost-effective pharmaceuticals, in accordance with the decisions of the CalOptima Health Pharmacy and Therapeutics (P&T) Committee, and compliant with federal requirements under the Affordable Care Act (ACA), 45 CFR § 156.122, and state requirements under the Knox-Keene Health Care Service Plan Act (KKA), as enforced by the Department of Managed Health Care (DMHC).

B. The CalOptima Health P&T Committee shall:

1. Consist of thirteen (13) members, including six (6) physicians and seven (7) pharmacists; and
2. Meet on a regular basis, but not less than quarterly.

C. On an annual basis, CalOptima Health's P&T Committee shall:

1. Review the PAD PA List and update as appropriate;
2. Review pharmaceutical management procedures and update as appropriate;

D. Decisions and recommendations of the P&T Committee shall be documented in minutes and reported to CalOptima Health's Utilization Management Committee.

- 1 E. CalOptima Health and its delegated Health Networks shall require a Prior Authorization for
2 medications and supplies that are listed on the PAD PA List.
3
- 4 F. CalOptima Health shall communicate the following information relating to PAD PA List
5 changes and updates and pharmaceutical management procedures to Members and Prescribing
6 Practitioners in writing annually:
7
- 8 1. Where to find the PAD PA List, including restrictions, on the CalOptima Health
9 website;
 - 10 2. How to use the pharmaceutical management procedures;
 - 11 3. An explanation of the PAD PA List limits and restrictions; and
 - 12 4. How Prescribing Practitioners must provide information to support a Prior Authorization
13 request.
- 14
- 15 G. The following information relating to the PAD PA List shall be posted on the CalOptima
16 Health website:
17
- 18 1. How to use the pharmaceutical management procedures;
 - 19 2. An explanation of what a PAD PA List is;
 - 20 3. How CalOptima Health decides which drugs are included on the PAD PA List;
 - 21 4. How often the PAD PA List is updated;
 - 22 5. How Prescribing Practitioners must provide information to support a Prior
23 Authorization request; and
 - 24 6. How the Members or Prescribing Practitioners can obtain a print version of the
25 PAD PA List.
- 26
- 27 H. CalOptima Health shall review and post the PAD PA List on CalOptima Health's website 30
28 calendar days in advance of any updates.
- 29
- 30 I. CalOptima Health's delegated Health Networks shall follow the PAD PA List when reviewing
31 authorization requests.
- 32
- 33 J. CalOptima Health's delegated Health Networks shall maintain appropriate communication
34 with the Provider and the Member (Enrollee) or the Member's Authorized Representative
35 (Enrollee Designee) throughout the PA process to facilitate delivery of appropriate services.
- 36
- 37 K. CalOptima Health's delegated Health Networks shall provide a written response to the Provider of
38 an approval, modification, deferral for Medical Necessity information, or denial to a preservice
39 authorization within twenty-four (24) hours of receipt of an exigent/urgent request, within seventy-
40 two (72) hours of receipt of a standard/non-urgent request, and thirty (30) calendar days for a
41 retrospective request.
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- 43 L. CalOptima Health's delegated Health Networks shall provide a written response to the Member or
44 the Member's Authorized Representative of an approval, modification, or denial to a preservice
45 authorization within twenty-four (24) hours of receipt of an exigent/urgent request, within seventy-
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two (72) hours of receipt of a standard/non-urgent, request and thirty (30) calendar days for a retrospective request.

- M. CalOptima Health's delegated Health Networks shall make prior authorization decisions based on medical necessity, appropriateness of care and service, and existence of coverage. CalOptima Health and its Health Networks do not reward Providers or other individuals for issuing denial for coverage, care, or services. CalOptima Health and its Health Networks do not provide financial incentives to decision-makers to encourage decisions that result in underutilization.
- N. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified medical director or clinical pharmacist with a current and unrestricted license to practice in California.
- O. For appropriately prescribed pain management medications for terminally ill patients when Medically Necessary, CalOptima Health's delegated Health Networks shall approve, defer for Medically Necessary information, or deny a PA in a timely fashion, appropriate for the nature of the Member's condition, and not to exceed twenty-four (24) hours of receipt of an exigent/urgent request and seventy two (72) hours of receipt of a standard/non-urgent request.
1. If the request is denied, or if additional information is required to make a determination, CalOptima Health's delegated Health Networks shall contact the Provider within twenty-four (24) hours of receipt of the request, with an explanation of the reason for the denial or the need for additional information.
 2. Only licensed physicians or health care professionals (competent to evaluate the clinical issues) make decisions to modify or deny a PA for pain management for terminally ill patients.
 3. The requested treatment shall be deemed authorized as of the expiration of the applicable timeframe.
 4. CalOptima Health's delegated Health Networks shall notify the Member or the Member's Authorized Representative, and Provider of any approval, denial, modification, or reduction of the level of treatment or services currently underway, in a written DMHC approved Notice of Action (NOA), in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, within twenty-four (24) hours of receipt of an exigent/urgent request and within seventy-two (72) hours of receipt of a standard/non-urgent request.
- P. A Provider may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider's ability to obtain a Prior Authorization request within a reasonable established time limit, not to exceed sixty (60) calendar days from the date of service, in accordance with CalOptima Health Policy CC.1600: Authorization and Processing of Referrals.
- Q. CalOptima Health's delegated Health Networks shall require the use of a U.S. Food and Drug Administration (FDA)-approved and nationally marketed drugs, unless Medical Necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the Member and a compound alternative is Medically Necessary.

- 1 R. If CalOptima Health's delegated Health Networks fail to issue a DMHC approved NOA for Prior
2 Authorization requests within the required time frame, such request shall be deemed approved for
3 the duration of the prescription, including refills.
4
- 5 S. CalOptima Health's delegated Health Networks shall ensure the Prior Authorization process
6 for medications and supplies is consistently applied to medical/surgical, mental health, and
7 substance use disorder medications and supplies.
8
- 9 1. Coverage limits, such as quantity limits and utilization management restrictions, and co-
10 payments for mental health and substance abuse disorder shall be consistent with and not
11 more stringent than limits for medical/surgical drugs.
12
- 13 2. Financial requirements or treatment limitations for mental health and substance abuse
14 disorder drugs shall not be more restrictive than those applied to medical/surgical drugs.
15
- 16 T. CalOptima Health shall allow Continuity of Care in accordance with CalOptima Health
17 Policies CC.1600: Authorization and Processing of Referrals and CC.1500: Continuity of
18 Care for Members Transitioning into CalOptima Health Services.
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- 20 1. CalOptima Health's delegated Health Networks do not limit or exclude coverage for a
21 drug previously approved for an enrollee for the medication if the prescribing provider
22 continues to prescribe the drug and the drug is appropriately prescribed for treating the
23 enrollee's medical condition.
24
- 25 U. CalOptima Health Pharmacy Management shall review and update the CalOptima Health
26 Prior Authorization guidelines when appropriate and, at a minimum, on an annual basis.
27
- 28 V. CalOptima Health shall regularly monitor and oversee its delegated Health Networks and ensure
29 that its delegates and subcontractors comply with all applicable requirements of this policy, the
30 Knox-Keene Act, and CalOptima Health policies, including CalOptima Health Policies GG.1541:
31 Utilization Management Delegation and GG.1619: Delegation Oversight.
32
- 33 K. CalOptima Health and its delegated Health Networks shall establish a process to monitor the
34 appropriate utilization of medical care and services delivered to Members and ensure that care is
35 monitored, analyzed, and interventions are implemented upon the identification of under and over
36 utilization patterns in accordance with CalOptima Health Policies GG.1532: Over and Under
37 Utilization Monitoring and GG.1541: Utilization Management Delegation.
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39 III. PROCEDURE

40 A. The P&T Committee shall:

- 41
- 42 1. Approve all changes and updates to the PAD PA List;
- 43
- 44 2. Approve the inclusion or exclusion of classes of drugs in the PAD PA List;
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- 46 3. Review Prior Authorization guidelines;
- 47
- 48 4. Base clinical decisions on the strength of scientific evidence, standards of practice,
49 and safety and efficacy considerations; and
- 50
- 51 5. Consider use of the following resources to assist in decision-making: Milliman
52 Care Guidelines, CMS recognized compendia (American Hospital Formulary
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System Drug Information, Micromedex, Clinical Pharmacology, National Comprehensive Cancer Network Drugs and Biologicals compendium) and standards of practice, including peer reviewed medical literature, well-established clinical practice guidelines, and pharmacoeconomic studies, as well as other sources of appropriate information.

- B. As part of the PAD PA List decision process, the P&T Committee may elect to set specific usage criteria of pharmaceuticals based on safety, efficacy and cost as follows:
1. Drug class reviews;
 2. Drugs that are preferred;
 3. Prior Authorization guidelines for drugs that are not preferred;
 4. Duration of therapy limits;
 5. Limiting access to drugs within certain classes; and
 6. Evidence that preferred-status drugs may produce similar, or better, results for the majority of the population compared to other drugs within the same class.
- C. CalOptima Health shall post a summary of changes document to the PAD PA List on the CalOptima Health website following each P&T Committee meeting. The document shall be in a machine-readable format as well as in a print version available to Members and Prescribing Practitioners upon request.
- D. A Provider shall utilize only California's "Prescription Drug Prior Authorization or Step Therapy Exception Request Form," Form No. 61-211 (the "Medication Request Form") and/or an electronic PA system.
- E. CalOptima Health's Delegated Health Networks shall make the Medication Request Form (Form No. 61-211) and/or Electronic Request Form or Process electronically available on their website.
- F. CalOptima Health's delegated Health Networks shall review and classify all PA requests based on the following:
1. Urgent Pre-Service Request;
 2. Standard Request (non-urgent Pre-Service Request); and
 3. Post-Service Request.
- G. CalOptima Health's delegated Health Networks shall review all PA requests based on the Member's individual needs, medical necessity, and in accordance with CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines.
1. Requests shall also be evaluated to consider the Member's condition, age, gender, Health Network (to ensure appropriate responsibility for coverage), place of residence, and for other payers or other insurance coverage.
 2. CalOptima Health's delegated Health Networks shall obtain all clinical information, relevant to a Member's care, to render a decision. Decisions to deny or to authorize an amount,

duration, or scope less than the requested health care services shall be made by a qualified medical director or clinical pharmacist with a current and unrestricted license to practice in California.

3. If the PA request has sufficient clinical information to meet medical necessity, CalOptima Health's delegated Health Networks shall approve the PA and notify the Provider by facsimile and/or electronically within twenty-four (24) hours of receipt of an exigent/urgent request and within seventy-two (72) hours of receipt of a standard/non-urgent request.
 4. If the PA request has insufficient information to meet medical necessity, CalOptima Health's delegated Health Network shall defer the PA for additional Medical Necessity information and notify the Provider by facsimile and/or electronically.
 - a. The notice shall include a reason for the deferral and date of when a response is needed to render a decision.
 5. If all information reasonably necessary to make a determination was not received or insufficient for approval, CalOptima Health's delegated Health network shall render a decision within twenty-four (24) hours of receipt of the request of an exigent/urgent request and within seventy-two (72) hours of receipt of a standard/non-urgent request.
 - a. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified medical director or clinical pharmacist with a current and unrestricted license to practice in California.
- H. CalOptima Health's delegated Health Networks shall notify the Member or the Member's Authorized Representative, and Provider, of any approval, denial, modification, or reduction of the level of treatment or services currently underway, or medication carve out, in a written Notice of Action (NOA), in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, within twenty-four (24) hours of receipt of an exigent/urgent request and within seventy-two (72) hours of receipt of a standard/non-urgent request.
- I. The written NOA shall contain information as required by applicable state and federal regulations and outlined in the CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. It shall also:
1. Provide a statement of action CalOptima Health's delegated Health Networks is taking on the request;
 2. Clearly and concisely describe the specific reason(s) for the denial, modification or reduction of the level of treatment or services currently underway, in an easy to understand language (6th grade level or less) and provide a reference to the Guidelines on which the decision was based;
 3. Contain all of the following for decisions based in whole or in part on Medical Necessity:
 - a. Provide a description of the criteria or guidelines used to include a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guidelines;
 - b. Describe the clinical reasons for the decision and explicitly state how the Member's

condition does not meet the criteria or guidelines;

4. Define how the Provider may request, free of charge, copies of all documents and records relevant to the NOA, including the actual benefit provision, guideline, protocol, or other criteria on which the decision was based;
 5. Inform the Provider of the availability of an appropriate practitioner to discuss the denial and provide contact instructions;
 6. Include the name and direct telephone number of the decision maker on the Provider notification;
 7. Include information on how the Member or the Member's Authorized Representative may file a Grievance or Appeal with CalOptima Health and a copy of the Member Grievance Process, which describes the standard and expedited Grievance process and time limits for filing a Grievance in accordance with CalOptima Health Policies CC.1200: Member Appeal Process and CC.1201: Member Grievance;
 8. Include information on how the Member or Member's Authorized Representative may file an external exception request review (Independent Medical Review) in accordance with Health & Safety Code § 1368.02;
 - a. Include the following paragraph in denial letters:
 - i. The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a Grievance against your health plan, you should first telephone your health plan at 714-246-8500 and use your health plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, Coverage Decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-tree telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.
 9. Explain that the Member, the Member's Authorized Representative or Provider can submit written comments, documents, or other information to Appeal the denial; and
 10. Include a "Your Rights" attachment, along with the nondiscrimination notice and Notice of Availability of Language Assistance Services and Auxiliary Aids and Services, as set forth in CalOptima Health Policy GG.1507: Notification Requirements for Covered Service Requiring Prior Authorization.
- J. CalOptima Health's delegated Health Networks shall translate NOA letters into Threshold Languages as applicable and offer oral Interpretation for all other languages, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

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2 K. CalOptima Health's delegated Health Networks shall communicate the decision to approve,
3 modify or deny a request, to the Member or Member's Authorized Representative, in writing,
4 which shall be dated and postmarked within twenty-four (24) hours of receipt of an
5 exigent/urgent request, seventy-two (72) hours of receipt of a standard/non-urgent request and
6 thirty (30) calendar days for a retrospective request.
7
8 L. CalOptima Health's delegated Health Networks shall notify the Provider of the decision to
9 approve, modify or deny a request in writing, which shall be dated within twenty-four (24)
10 hours of receipt of an exigent/urgent request, seventy-two (72) hours of receipt of a
11 standard/non-urgent request, and thirty (30) calendar days for a retrospective request.
12
13 M. In accordance with CalOptima Health Policy CC.1200: Member Appeal Process, a Provider,
14 Member, or Member's Authorized Representative may Appeal any decision that involves
15 the delay, modification, or denial of services based on Medical Necessity, , or reduction of
16 the level of treatment or services currently under way, or a determination that the requested
17 service was not a covered benefit within one hundred eighty (180) days from the date of a
18 service denial letter.
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20 N. CalOptima Health shall monitor Health Network compliance with this Policy in accordance
21 with CalOptima Health Policy GG.1619: Delegation Oversight.
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23 **IV. ATTACHMENT(S)**

24 Not Applicable
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27 **V. REFERENCE(S)**
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- 29 A. California Business and Professions Code, Section 4039
30 B. California Department of Managed Health Care (DMHC) All Plan Letter (APL) 25-004: AB
31 118: Part 1 - Compliance with Large Group Standardized Evidence of Coverage/Disclosure
32 Form, Attachment 1: Exclusions and Limitations and Attachment 2: Members' Rights and
33 Responsibilities
34 C. California Department of Managed Health Care (DMHC) Technical Assistance Guide:
35 Prescription Drug Coverage
36 D. California Health and Safety Code, §§ 1367.025; 1367.241(b)(1)(A) and (b)(2); 1367.01(e) and
37 (h)(3); 1367.215(a); 1367.21; 1367.206(d); 1367.22(a) and (b); 1368.02(b)
38 E. CalOptima Health Physician Administered Drug Prior Authorization Required List (PAD PA List)
39 F. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
40 G. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring
41 Prior Authorization
42 H. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
43 I. CalOptima Health Policy GG.1541: Utilization Management Delegation
44 J. CalOptima Health Policy CC.1200: Member Appeal Process
45 K. CalOptima Health Policy CC.1500: Continuity of Care for members Transitioning into CalOptima
46 L. CalOptima Health Policy CC.1600: Authorization and Processing of Referrals
47 M. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
48 N. CalOptima Health Policy GG.1619: Delegation Oversight
49 O. California Welfare and Institutions Code, Sections 14185
50 P. National Committee for Quality Assurance (NCQA) 2027 HP Standards and Guidelines -UM
51 Standards
52 Q. Title 28, California Code of Regulations, §§1300.67.04(a)(1); 1300.67.241(e)(4)(A) and (k)
53 R. Title 42, California of Federal Regulations, §§ 422.138

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.1903	Cost Sharing for Qualified Health Plans	Covered California

For 20261001 BOD Review Only

1 IX. GLOSSARY

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Term	Definition
Appeal	A type of Grievance related to a Member appeal within CalOptima Health's Grievance system. A type of Grievance related to any of the following medical necessity determination or coverage actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability.
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 DHCS State Fair Hearings, 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.
Grievance	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 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. An inquiry is not a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, the incident must be considered a Grievance. A Grievant is the individual making or filing the Grievance.
Enrollee	Also referred to as a Member, means each and every individual enrolled for the purpose of receiving health benefits in the health plan or market referenced. If no health plan or market is referenced, this term is used to reference individuals enrolled in both on-exchange QHPs and off-exchange mirrored products in the individual market.

Term	Definition
Health Network	A medical group that is a Participating Health Care Provider that is contracted with CalOptima Health to provide Covered Benefits to Members.
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).
Member	An individual enrolled in a CalOptima Health program.
Pre-Service Request	A request for coverage of pharmaceutical services that CalOptima Health must approve in advance, in whole or in part.
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.
Retrospective Request	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, because the Member faces an imminent and serious threat to the Member's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the Member's life or health or could jeopardize the Member's ability to regain maximum function.



Policy: CC.1904
Title: **Notification Regarding Medication Recalls**
Department: Pharmacy Management
Section: Not Applicable

CEO Approval: /s/

Effective Date:
Revised Date:

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

I. PURPOSE

This policy describes the process by which CalOptima Health notifies Members or the Member's Authorized Representative and Prescribers of Medication Recalls and Market Withdrawals.

II. POLICY

- A. CalOptima Health pharmacists shall monitor the U.S. Food and Drug Administration (FDA) Enforcement Report to obtain information on actions taken in connection with agency regulatory activities regarding Medication Recalls and Market Withdrawals.
- B. When the medication recall is not limited to specific medication batches or lot numbers, CalOptima Health's Pharmacy Management Department shall notify Members or Member's Authorized Representative and prescribers, in writing, when there is a Class I or Class II Medication Recall, or when a medication is withdrawn from the market.
- C. Member notification shall be in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- D. On an annual basis, the CalOptima Health Pharmacy Management Department shall review the Medication Recall and Market Withdrawal notification procedures.

III. PROCEDURE

A. Medication Recalls and Market Withdrawals

- 1. On a weekly basis, the FDA publishes and posts the FDA Enforcement Report on the FDA Website: www.fda.gov.
- 2. CalOptima Health pharmacists shall review the FDA Enforcement Report for Medication Recalls and Market Withdrawals.
- 3. CalOptima Health pharmacists shall review pharmacy claims data to identify Members and prescribers potentially affected by an FDA Medication Recall or a Market Withdrawal.

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- a. In the event the FDA issues a Class I Medication Recall, CalOptima Health pharmacists shall:
 - i. Identify affected Members and prescribers through pharmacy utilization reports within five (5) calendar days of the FDA medication recall announcement;
 - ii. Notify affected Members or Member's Authorized Representative, in writing via U.S. mail, as soon as the Members are identified, but no later than five (5) calendar days from the date of the FDA medication recall announcement;
 - iii. Notify affected prescribers, via facsimile, as soon as the prescribers are identified, but no later than five (5) calendar days from the date of the FDA announcement; and
 - iv. In instances where the recalled medication may cause serious adverse health consequences or death to Members, CalOptima Health may place a Prior Authorization restriction on the medication.
 - b. In the event the FDA issues a Class II Medication Recall, or a manufacturer withdraws a medication from the market, CalOptima Health pharmacists shall:
 - i. Identify affected Members and prescribers through pharmacy utilization reports within ten (10) calendar days of the FDA medication recall announcement or a manufacturer Market Withdrawal;
 - ii. Notify affected Members or Member's Authorized Representative, in writing via U.S. mail, as soon as the Members are identified, but no later than thirty (30) calendar days from the date of the FDA medication recall announcement or Market Withdrawal;
 - iii. Notify affected prescribers, via facsimile, as soon as the prescribers are identified, but no later than thirty (30) calendar days from the date of the FDA medication recall announcement or Market Withdrawal; and
 - iv. In instances where the medication may cause serious adverse health consequences or death to Members, CalOptima Health may place a Prior Authorization restriction on the recalled or withdrawn medication.
 - 4. CalOptima Health's Pharmacy Management Department shall track, and report medication recalls and manufacturer Market Withdrawals to CalOptima Health's Pharmacy and Therapeutics (P&T) Committee quarterly. The Committee shall determine the need for additional action and shall initiate changes to the Pharmacy Benefit Manager's Covered California Formulary and physician administered drug Prior Authorization required list (PAD PA List) as deemed necessary.

47 **IV. ATTACHMENT(S)**

- 48
49 A. Member Notification Form
50 B. Prescriber Notification Form
51 C. Template for reporting recalls and withdrawals to Pharmacy & Therapeutics Committee
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53 **V. REFERENCE(S)**

- A. 2027 National Committee for Quality Assurance (NCQA) HP Standards and Guidelines UM Standards
- B. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
- C. U.S. Food and Drug Administration (FDA) Enforcement Reports at www.fda.gov

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.1904	Notification Regarding Medication Recalls	Covered California

For 20261001BOD Review Only

IX. GLOSSARY

Term	Definition
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 DHCS State Fair Hearings, 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.
Class I Medication Recall	A situation in which there is a reasonable probability that the use of or exposure to a product will cause serious adverse health consequences or death.
Class II Medication Recall	A situation in which use of or exposure to a product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
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.
Market Withdrawals	A manufacturer's removal or correction of a distributed product that involves a minor violation which would not be subject to legal action by the Food and Drug Administration (FDA).
Member	An individual enrolled in a CalOptima Health program.
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).

July 25, 2023

«Member_First_Name» «Member_Last_Name»
«Member_Address_1» «Member_Address_2»
«Member_City», «Member_State» «Member_Zip_Code»

Subject: Notice of Drug Recall - <<ENTER DRUG NAME>>

Dear «Member_First_Name» «Member_Last_Name»:

On <<DATE>>, <<NAME OF DRUG COMPANY>> has recalled all lots of <<ENTER DRUG NAME & RECALL INFO>>. The reason for the recall is because <<REASON FOR RECALL>>.

Our records show that you have filled this drug within the last 120 days. Please call your doctor's office immediately. **If you are not sure if your drug is part of this drug recall, you can call «Pharmacy_Name» at «Pharmacy_Phone_Number» where you filled your prescription.**

If you no longer take the drug listed above, please ignore this letter.

Sincerely,

Pharmacy Management

July 25, 2023

Dr. «Prescriber_First_Name» «Prescriber_Last_Name»
«Prescriber_Address_1» «Prescriber_Address_2»
«Prescriber_City», «Prescriber_State» «Prescriber_Zip_Code»

Subject: Notice of Drug Recall – <<ENTER DRUG NAME>>

Dear Dr. «Prescriber_Last_Name»:

On <<DATE>>, the U.S. Food and Drug Administration (FDA) announced that <<NAME OF DRUG COMPANY>> has recalled all lots of <<ENTER DRUG NAME & RECALL INFO>>. This recall affects all lot numbers of the following products:

Product Description	NDC

A complete copy of the FDA Med Watch may be viewed at
<https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts>

Sincerely,



Himmet Dajee, M.D.
Medical Director, Medical Management



**Pharmacy and Therapeutics Committee
Drug Recalls and Withdrawals QQYY
Date**

Date	Class I Recalls	Drug Name	Recall Reason	CalOptima Action Taken
-	0	-		-

Date	Class II Recalls	Drug Name	Recall Reason	CalOptima Action Taken
-	0	-		-

Recall Date	Recall Type	Drug Name	Manufacturer	Recall Reason	# Members Impacted	# Prescribers Impacted	CalOptima Action Taken

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve CalOptima Health Operations Policies Related to Covered California

Contact

Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action

Approve policies and procedures developed or updated to reflect operational requirements for CalOptima Health's Covered California product, effective January 1, 2027:

1. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint;
2. CalOptima Health Policy CC.1200: Member Appeal Process;
3. CalOptima Health Policy CC.1201: Member Grievance;
4. CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment;
5. CalOptima Health Policy DD.2005: Member Informing Materials Requirements;
6. CalOptima Health Policy DD.2001: Member Rights and Responsibilities; and
7. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

Background

Over the past two years, CalOptima Health has made significant progress in preparing to enter the Covered California program. The CalOptima Health Board of Directors (Board) has taken several actions related to Covered California. On August 1, 2024, the Board authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee comprising key external partners and providers to discuss considerations regarding potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met nine times. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California.

On August 6, 2026, the Board authorized CalOptima Health to execute the Qualified Health Plan contract with Covered California. On August 11, 2026, CalOptima Health received conditional approval from the Department of Managed Health Care (DMHC) to expand the scope of its current Knox-Keene Act license to enable CalOptima Health to offer the Covered California product.

Discussion

On June 5, 2025, the Board approved several CalOptima Health policies related to Covered California regulatory requirements as part of the DMHC filing process. The process required submission of at least 89 supporting exhibits demonstrating compliance with the requirements of the Knox-Keene Act.

In addition to regulatory policies approved by DMHC, staff evaluated several operational policies and procedures, determining that updates to the policies were required. While these policy updates do not currently require DMHC approval, they are required to support the implementation of CalOptima Health's Covered California product.

In the area of Operations, staff recommends approval of one (1) new policy and two (2) updated policies and procedures related to grievances and appeals. In addition, staff recommends approval of updates to four (4) current customer service policies and procedures. Staff seeks Board approval for all seven (7) policies effective January 1, 2027.

Policies & Procedures Summary – Grievances and Appeals

<i>Policy</i>	<i>Summary of Change/Update</i>
CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint	New policy for the Covered California product to receive, investigate, resolve, track, and report contracted and non-contracted provider complaints in accordance with applicable statutory, regulatory, and contractual requirements.
CalOptima Health Policy CC.1200: Member Appeal Process	Updated policy for the Covered California product to review, address, and resolve standard and expedited pre-service and post-service member appeals determinations.
CalOptima Health Policy CC.1201: Member Grievance	Updated policy for the Covered California product to address and resolve grievances from a member, provider, or authorized representative acting on behalf of a member with the member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements.

Policies & Procedures Summary – Customer Service

<i>Policy</i>	<i>Summary of Change/Update</i>
CalOptima Health Policy DD.2006b: Member Primary Care Provider (PCP) and Health Network (HN) Selection/Assignment	1. Updated policy for auto-assignment processes for new Covered California members implementing the following: 2. New members entering CalOptima Health's network who do not have a PCP or HN will follow the auto-assignment process in CalOptima Health Policy

<i>Policy</i>	<i>Summary of Change/Update</i>
	AA.1207a: CalOptima Health Auto-Assignment. 3. Once the new member runs through the auto-assignment process and wants to select a new PCP or HN, the member selection process is followed, as specified in CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment.
CalOptima Health Policy DD.2005: Member Informing Materials Requirements	Updated policy to list materials CalOptima Health will send to Covered California members.
CalOptima Health Policy DD.2001: Member Rights and Responsibilities	Updated policy to include and outline the members' rights and responsibilities as a Covered California member.
CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services	Updated policy to include requirements to inform Covered California members when a provider terminates or changes availability or location of covered services.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what is included in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

Approval of updated and new policies and procedures related to Operations will support CalOptima Health's operational implementation of the Covered California product.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint
2. CalOptima Health Policy CC.1200: Member Appeal Process
3. CalOptima Health Policy CC.1201: Member Grievance
4. CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment
5. CalOptima Health Policy DD.2005: Member Informing Materials Requirements
6. CalOptima Health Policy DD.2001: Member Rights and Responsibilities
7. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services



Policy: CC.1202
Title: **CalOptima Health Covered Provider Complaint**
Department: Grievance and Appeals Resolution Services
Section: Not Applicable

CEO Approval: /s/

Effective Date:

Revised Date:

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

I. PURPOSE

This policy defines the process by which CalOptima Health Covered, Health Networks, and Third-Party Administrators (TPA) receive, investigate, resolve, track, and report contracted and Non-Contracted Provider Complaints in accordance with applicable statutory, regulatory, and contractual requirements, and distinguishes Provider Complaint from enrollee grievances and Independent Medical Review requests.

II. POLICY

- A. CalOptima Health Covered, Health Networks, and TPAs shall maintain a fast, fair, and cost-effective system to process and resolve contracted Provider Complaints, in accordance with applicable statutory, regulatory, and contractual requirements. Providers are informed of the Complaint process in accordance with the CalOptima Health Covered Provider Manual.
- B. Providers shall utilize the Health Network and TPA grievance systems prior to filing a Complaint directly with CalOptima Health Covered, in accordance with this Policy.
- C. Complaints submitted on behalf of a Member related to Appeals of Medical Necessity will be processed in accordance with CalOptima Health Covered Policy CC.1200: Member Appeal Process.
 1. If a matter involves the denial, modification, or delay of health care services based in whole or in part on a determination that the service is not Medically Necessary or is otherwise a clinical coverage decision, the request shall be processed under the enrollee grievance, Appeal, and Independent Medical Review (IMR) framework, as applicable. Such matters are excluded from this Provider Complaint process and must follow the procedures set forth in the Plan's Member Appeal and Grievance policies.
- D. CalOptima Health Covered, Health Networks, and TPAs shall promptly review and investigate Complaints and resolve them, in accordance with the timeframes set forth herein.
- E. CalOptima Health Covered, Health Networks, and TPAs shall not discriminate or retaliate against any Provider (including, but not limited to, terminating the Provider's contract) on grounds that

such Provider filed a Complaint, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

- F. CalOptima Health Covered, Health Networks, and TPAs shall designate a Principal Officer to be primarily responsible for the maintenance, oversight, and analysis of trends and preparation of reports related to Provider Complaints as required by this Policy and applicable regulations.
- G. CalOptima Health Covered, Health Networks, and TPAs shall not impose a deadline for receipt of a Provider Complaint for a claims payment Dispute that is less than three hundred sixty-five (365) calendar days after the date of an action or, in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the time for contesting or denying the claim has expired.
- H. If the Dispute relates to a demonstrable and unfair payment pattern by CalOptima Health Covered, or CalOptima Health's Capitated Provider, neither CalOptima Health Covered nor the Capitated Provider shall impose a deadline for the receipt of a Dispute that is less than three hundred sixty-five (365) calendar days from CalOptima Health's or the Capitated Provider's most recent action, or in the case of inaction, that is less than three hundred sixty-five (365) calendar days after the most recent time for contesting or denying claims has expired.
- I. CalOptima Health Covered, Health Networks, and TPAs shall not charge a Provider for the cost of processing a Provider Complaint. Notwithstanding the foregoing, CalOptima Health Covered, Health Networks, and TPAs shall have no obligation to reimburse a Provider for any costs incurred in connection with utilizing the Provider Complaint process.
- J. A Health Network and TPA shall make available to CalOptima Health Covered and the Department of Managed Health Care (DMHC) all records, notes, and documents regarding its Provider Complaint Resolution mechanism(s) and the Resolution of Provider Complaints.
- K. CalOptima Health Covered shall submit an annual report to DMHC that includes but is not limited to the total number of Providers who have utilized the Dispute mechanism, delineated by Providers, Network Providers, Subcontractors, and Downstream Subcontractors and a summary of the disposition of those Disputes.
- L. CalOptima Health Covered shall have the right to extend or stay the implementation of a decision or require a Health Network or TPA to delay or stay such a decision, in order to allow the affected Provider an opportunity to file a Complaint under this Policy.
- M. CalOptima Health Covered will accept Disputes related but not limited to the authorization of a denial of a service, the processing of a payment or non-payment of a claim, the timeliness of the reimbursement on an uncontested clean claim and any applicable interests.
- N. A Provider who seeks to contest any decision made by CalOptima Health Covered pursuant to this Policy is required to comply with CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, if applicable.
- O. A Provider can also file a complaint directly with the Department of Managed Health Care (DMHC) as follows:
 - 1. Within thirty (30) months from the last date of service of the claim.
 - 2. Provider is required to submit the dispute to CalOptima Health Covered for a minimum of 45 working days or until receipt of CalOptima Health's written determination; whichever period is shorter.

III. PROCEDURE

A. Submission of a Complaint

1. A Complaint shall contain the following:
 - a. Provider Dispute Resolution (PDR) Form, Appeal, or Dispute Letter and supporting documents.
 - b. Provider name and Provider Identification Number (PIN);
 - c. Contact information;
 - d. Claim number assigned to the original claim, if applicable;
 - e. Clear description of the Dispute;
 - f. Date of service;
 - g. Clear explanation of the basis upon which the Provider believes the action is incorrect;
 - h. If the Complaint involves a bundled group of multiple claims that are substantially similar, identification of the original claim number; and
 - i. If the Complaint involves a Dispute involving a Member or group of Members, the name(s) and identification number(s) and Claim numbers (if applicable) of the Member(s), a clear explanation of the Disputed item(s), includes the date(s) of service, and the Provider's position on the issue(s).
2. A Provider may submit an amended Provider Complaint within thirty (30) business days of the date or receipt of a returned Provider Complaint that is missing required information.
3. A Provider that has furnished Covered Services to a Member for which a Health Network is financially responsible, or is dissatisfied with any aspect of a Health Network's program, shall file a Complaint with that Health Network prior to filing a Complaint with CalOptima Health Covered within three hundred sixty-five (365) calendar days after the Health Network's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.
4. A Provider that has furnished Covered Services to a Member that is dissatisfied with any aspect of a TPA's program, shall file a Complaint with that TPA prior to filing a Complaint with CalOptima Health Covered within three hundred sixty-five (365) calendar days after the TPA's action, or in the case of inaction, within three hundred sixty-five (365) calendar days after the time for contesting or denying claims has expired.
5. A Provider may file a Complaint with CalOptima Health Covered as follows:
 - a. The Provider has provided Covered Services to a Member for which CalOptima Health Covered is financially responsible, or is dissatisfied with any aspect of CalOptima Health Covered;

b. The Provider has provided Covered Services to a Member for which a Health Network or TPA is financially responsible, is dissatisfied with a Complaint Resolution Letter received from the Health Network or TPA, as set forth in this Policy, and files within the following timeframes:

- i. Sixty (60) calendar days after the date of the Health Network's or TPA's Complaint Resolution Letter for Complaints related to Medical Necessity; or
- ii. One hundred eighty (180) calendar days after the date of the Health Network's or TPA's Complaint Resolution Letter for all other types of Complaints.

B. CalOptima Health Covered, a Health Network or TPA Complaint Receipt and Resolution

1. Record of Complaint

- a. CalOptima Health Covered or Health Network shall enter into its Complaint tracking system each Complaint (whether or not complete) received and create an electronic or hard copy file.
- b. A TPA shall track and maintain records of each Complaint (whether or not complete) it receives.

2. Acknowledgement of Complaint

- a. CalOptima Health Covered, Health Network or TPA shall acknowledge the receipt of a Complaint in paper form (whether or not complete) within fifteen (15) business days of the date of receipt by the office or department designated to receive Complaints.
- b. CalOptima Health Covered, Health Network or TPA shall acknowledge the receipt of a Complaint in electronic form (whether or not complete) within two (2) business days of the date of receipt by the office or department designated to receive Complaints.

3. Incomplete Complaints

- a. CalOptima Health Covered, a Health Network or TPA may return to a Provider any Complaint lacking the required information or information necessary to determine payer liability that is in the possession of the Provider and not readily accessible to CalOptima Health, Health Network or TPA.
- b. The returned Complaint shall clearly identify, in writing, the missing reasonably relevant information or information necessary to determine payer liability. In no event shall CalOptima Health Covered, a Health Network or TPA request the Provider to resubmit claim information that the Provider previously and appropriately submitted to CalOptima Health Covered, the Health Network or TPA as part of the claims adjudication process, except in those cases in which the claim documentation was returned to the Provider.

4. Investigation and Resolution of Complaints

a. Investigation

- i. CalOptima Health Covered, a Health Network or TPA shall promptly investigate a Complaint by consulting, as applicable, with the appropriate departments at CalOptima Health Covered, the Health Network department(s), or TPA responsible for the services

or operations that are the subject of the Complaint (e.g., Contracting, Utilization Management, Claims).

- ii. The applicable CalOptima Health Covered, Health Network or TPA department(s) shall investigate the factual matters that are the subject of the Complaint and shall report factual findings and a proposed resolution to CalOptima Health Covered or Health Network Grievance staff within ten (10) business days after initial receipt of the Complaint.
- iii. The applicable CalOptima Health Covered, Health Network or TPA department shall use the Complaint Referral and Investigation Request Form, or a similar form, to report findings and proposed resolutions to the CalOptima Health or Health Network Grievance staff, as set forth in this Policy.
- iv. CalOptima Health Covered may request that the Provider submit any written materials relevant to the Provider's Complaint.
- v. If the Provider is Appealing a Health Network or TPA Complaint Resolution Letter, CalOptima Health Covered shall review the Health Network or TPA Complaint file.
- vi. If a Complaint or Appeal of a contested claim involves a clinical issue, the necessity for treatment, or the type of treatment proposed or utilized, CalOptima Health Covered shall refer the matter to the Medical Director or another appropriately licensed health care Provider. The reviewer shall determine whether he or she is competent to evaluate the specific clinical issues presented. If not, the reviewer shall consult with an appropriately licensed health care Provider competent to evaluate the specific clinical issues before making a determination. For purposes of this Policy, "competent to evaluate the specific clinical issues" means that the reviewer has education, training, and relevant expertise pertinent to the specific clinical issues that form the basis of the contested claim.

b. Resolution

- i. CalOptima Health Covered, a Health Network or TPA shall resolve and issue a Complaint Resolution Letter for each Complaint it receives within forty-five (45) business days after the date of receipt of the Complaint or amended Complaint, in accordance with applicable laws, including those regulatory provisions identified in Title 28, California Code of Regulations, §1300.71.38(f). Additional time may be taken only if the Provider and CalOptima Health Covered agree to an extension. Extensions must be Provider-initiated or Provider approved.
- ii. The Complaint Resolution Letter shall describe the pertinent facts of the Complaint, the reasons for a CalOptima Health Covered, Health Network, or TPA determination, and applicable Provider Appeal rights, including the following:
 - a) For Complaints related to Medical Necessity, the right to Appeal the determination to the GARS Department within sixty (60) calendar days after the date of the Health Network or TPA Complaint Resolution Letter; or
 - b) For other Complaints, the right to request a Legal Claim pursuant to CalOptima Health Policy AA.1217: Legal Claims and Judicial Review.

c. Implementation of Complaint Resolution

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- i. CalOptima Health Covered and its Health Networks or TPA shall take immediate action to implement the determinations set forth in a Complaint Resolution Letter.
 - ii. If the Complaint or amended Complaint is determined in whole or in part in favor of the Provider, the Health Network shall pay:
 - a) Any outstanding monies that it determines to be due; and
 - b) All interest and penalties required within five (5) business days after the date of the Complaint Resolution Letter, pursuant to CalOptima Health Policy CC.1001; Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.
 - iii. Accrual of interest and penalties for the payment of any Resolved Complaints shall commence on the day following the expiration of the time for reimbursement.
- a. Resolution of Complaints submitted by Provider to CalOptima Health Covered
- i. GARS staff shall review the factual findings, proposed Resolution, and any other relevant information, and shall issue a decision with respect to the Complaint or amended Complaint, in accordance with CalOptima Health Policy HH.1109: Complaints Decision Matrix.
 - ii. Within forty-five (45) business days after receipt of the Complaint or amended Complaint, GARS staff shall send a Complaint Resolution Letter to the Provider.
- b. Implementation of Resolution by CalOptima Health Covered
- i. CalOptima Health Covered may take immediate action, or, as appropriate, require that a Health Network or TPA take immediate action to implement the decision set forth in CalOptima Health's Complaint Resolution Letter.
 - ii. If the Complaint is a payment-related issue, and CalOptima Health Covered determines that a Health Network is financially responsible, the Health Network shall make payment in the amount specified by CalOptima Health Covered to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The Health Network shall send written proof of payment to GARS staff.
 - iii. If the Health Network does not pay the claim as required by this Policy, CalOptima Health Covered shall pay the claim on behalf of the Health Network and shall deduct from the Health Network's capitation payment the amount paid on behalf of the Health Network plus the greater of a two hundred fifty-dollar (\$250.00) administrative fee or ten percent (10%) of the amount paid.
 - iv. If the Complaint is a payment-related issue, and CalOptima Health Covered determines that a TPA is financially responsible, the TPA shall make payment in the amount specified by CalOptima Health Covered to the Provider within five (5) business days after the date of CalOptima Health's Complaint Resolution Letter. The TPA shall send written proof of payment to GARS staff.

C. CalOptima Health Covered Responsible Staff

1. The GARS Director shall have primary responsibility for the maintenance of the Provider Complaint process.
2. The CalOptima Health Chief Operations Officer shall have primary responsibility for the oversight and review of operations, and for identifying any emergent patterns of Complaints to improve administrative capacity, provider relations, claims payment procedures, and Member care.

D. CalOptima Health Covered Monitoring

1. CalOptima Health Covered, Health Networks and TPAs shall continuously monitor for trends and systemic issues. If any trends are identified, a performance or Corrective Action Plan shall be developed to address the trend. CalOptima Health Covered shall monitor for performance improvement.
2. On an annual basis, CalOptima Health Covered shall assess all Disputes received to identify any overall trends or systemic issues and identify the root cause. Based on this annual assessment, CalOptima Health Covered shall develop a plan to address each trend or system issue identified. This report shall be submitted annually to DMHC.
3. If CalOptima Health Covered determines that a Health Network has failed to comply with any requirements of this Policy, CalOptima Health Covered may take appropriate action, including, but not limited to, imposing Corrective Action Plans or Sanctions against the Health Network under CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions.
4. CalOptima Health Covered shall monitor a TPA in accordance with CalOptima Health policy.

E. Notices, Records, and Reports

1. Notice to Providers of Complaint Procedure

- a. CalOptima Health Covered and Health Networks shall include a reference to this Policy in each Provider contract.
- b. CalOptima Health Covered and Health Networks shall notify Non-Contracted Providers of the availability of a Provider Complaint process. This notification may be satisfied through the Health Network's routine Provider communication processes, including, but not limited to, newsletters, bulletins, policy and procedure manuals, remittance advice notices, and Websites.

2. Records

- a. CalOptima Health Covered, Health Networks, and TPAs shall maintain written records of each Complaint, including at least the following information: date of receipt, Provider's name; name(s) of staff who received the Complaint and is designated as the contact person, description of the Complaint, medical records, documents, evidence of coverage and other relevant information upon which CalOptima Health Covered, Health Networks, and TPAs relied on in reaching its decision and disposition for ten (10) years.
- b. CalOptima Health Covered, Health Networks and TPAs shall retain written records of each Complaint, including copies of all Complaints and responses thereto, including all notes, documents, and other information upon which CalOptima Health Covered, the Health

1 Network, or TPA relied upon to reach its decision for a period of ten (10) years following
2 the termination of their contracts with CalOptima Health Covered. A Health Network and
3 TPA shall make records for the last two (2) years available on-site.
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- 5 c. A Health Network and TPA shall make available warehoused or stored records within five
6 (5) business days after a request for such records by CalOptima Health Covered or DMHC.
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8 3. Reporting Provider Complaint Activity
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- 10 a. At a maximum, on a monthly basis, a Health Network shall submit to the CalOptima Health
11 Covered Delegation Oversight Department.
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13 b. Each claim within a Complaint that has bundled substantially similar claims Disputes must
14 be listed separately as individual Complaints (including original claim numbers) on the
15 report.
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17 c. A Principal Officer shall sign the report certifying that the report is true and correct, to the
18 best of their knowledge and belief.
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20 F. Other Provider Rights. In addition to any rights set forth in this Policy and allowed by law, a
21 Provider also has the following rights:
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- 23 1. Claim Resubmission. Prior to filing a Complaint related to payment of a claim, a Provider may
24 resubmit the claim to the Health Network or TPA, as appropriate, in accordance with the
25 applicable Health Network, or TPA, claim resubmission policy.
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27 2. Provider's Right to Hearing
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29 a. Request for Hearing
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31 i. A Provider that Disputes recoupment of funds based upon audit findings of
32 overpayments, the imposition of Sanctions or penalties, or suspension or termination of
33 the Provider's participation in CalOptima Health Covered, a Health Network or TPA,
34 may request a hearing before the Provider Grievance Review Panel if:
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36 a) The Provider has received a Complaint Resolution Letter from CalOptima Health
37 Covered; or
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39 b) The Provider has received a Complaint Resolution Letter from a Health Network or
40 TPA and pursues a hearing in lieu of filing a written Complaint to CalOptima
41 Health Covered under Section III.A of this Policy.
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43 ii. No other hearings are provided under this Policy.
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45 iii. A Provider may submit to GARS staff a written request for hearing within fifteen (15)
46 calendar days after CalOptima Health's, a Health Network's or TPA's issuance of a
47 Complaint Resolution Letter. The written request shall set forth with specificity the
48 reasons for the hearing, including if the Provider challenges:
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50 a) The factual basis of the decision, and if so, which facts in particular;
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52 b) The legal basis for the decision; or
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c) The reasonableness of the decision, Sanctions, or penalties imposed.

b. Acknowledgment of Request for Hearing

- i. Upon receipt of a request for hearing, CalOptima Health Covered shall set a hearing date to be held within thirty (30) calendar days after receipt of the request.
- ii. CalOptima Health Covered shall send to the Provider a Hearing Acknowledgment Letter within five (5) calendar days after the Provider's request for a hearing, setting forth the date, time, and location of the hearing.

c. Hearing

- i. The purpose of the hearing is to afford the Provider an opportunity to contest the factual or legal basis of the decision, or the reasonableness of the decision.
- ii. The hearing is intended to be informal in nature. Formal rules of evidence and discovery do not apply. There shall be no cross-examination of witnesses. The Provider, CalOptima Health Covered, Health Network, and TPA, as appropriate, shall have the opportunity to present oral testimony and documentary evidence.
- iii. The Provider Grievance Review Panel shall select a hearing officer to preside at the hearing. The hearing officer may, from time to time, establish hearing guidelines governing the hearing procedure. The hearing officer may ask questions to any party at the hearing and shall ensure proper decorum at the hearing.
- iv. The hearing officer may cause a recording of the hearing to be made, either by tape recording or providing a court reporter service.
- v. After the conclusion of the hearing, the Provider Grievance Review Panel may adopt, reject, or modify, in whole or in part, the actions addressed at the hearing. The hearing officer shall send the Provider Grievance Review Panel's written decision to the Provider, Health Network, and TPA, as appropriate, within forty-five (45) calendar days after the close of the hearing. The decision shall be effective on the date issued by the hearing officer.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Health and Safety Code, § 1365, 1367.01(e),(h)(3), and (j), 1368 (a)(1), (a)(4)(B), 1368.01(a)-(b), 1368.016, 1368.02(b), 1367.24, 1368.015, 1370.2, 1371.34, 1374.30 (e), (i), (j)(1) and (3) (l), (m), (n), 1374.31, 1374.34(a).
- B. CalOptima Health Contract with the Department of Managed Health Care (DMHC)
- C. CalOptima Health Contract with the California Department of Aging (CDA)
- D. CalOptima Health Contract with Covered California
- E. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review
- F. CalOptima Health Policy CC.1200: Member Appeal Process
- G. CalOptima Health Policy CC.1201: Member Grievance
- H. CalOptima Health Policy HH.1109: Complaints Decision Matrix
- I. CalOptima Health Policy HH.2002: Sanctions

- J. CalOptima Health Policy HH.2005: Corrective Action Plan
K. CalOptima Health Policy CC.1001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
L. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
M. CalOptima Health Provider Manual
N. Title 28, California Code of Regulations (C.C.R.), §1300.71.38
O. DMHC APL 25-007: Assembly Bill 3275 Guidance (Claim Reimbursement)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
	Department Managed Health Care (DMHC)	

VII. BOARD ACTION(S)

Date	Meeting
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective		CC.1202	CalOptima Health Covered Provider Complaint	Covered CA

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 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).
Capitated Provider	Providers that are reimbursed on a capitation basis.
Complaint Resolution Letter	A written statement explaining the disposition of an Appeal or Complaint based on a review of the facts, relevant information, and documentation.
Corrective Action Plan	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 Managed Health Care (DMHC), 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 Covered and its regulators.
Covered Service	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.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations and other managed care plans.
Provider Dispute	A Provider Dispute is a written request challenging, appealing, or requesting reconsideration of a specific action or inaction by CalOptima Health Covered, a Health Network, or a TPA, including a denied, adjusted, or contested claim, a request for reimbursement of an overpayment, a billing determination, or other determination subject to applicable provider dispute resolution requirements. A Provider Dispute is processed under the formal dispute resolution timeframes and procedures set forth in this Policy and applicable law.
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.
Independent Medical Review (IMR)	A review of the CalOptima Health Covered denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on CalOptima Health pursuant to Health and Safety Code § 1374.30 and Title 28 California Code of Regulations §1300.74.30.
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

Term	Definition
	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	An individual enrolled in a CalOptima Health program.
Multipurpose Senior Services Program (MSSP)	The Waiver program that provides social and health care management to a Member who is sixty-five (65) years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home, pursuant to the Medi-Cal 2020 Waiver.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Non-Contracted Provider	A Provider who is not obligated by a written contract to provide Covered Services to a Member.
Principal Officer	Means a president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.
Provider Complaint	A Provider Complaint is a request for review submitted by a Provider regarding CalOptima Health, a Health Network, or a TPA about administrative processes, utilization management decisions, claims or payment issues, contract performance, or other operational concerns.
Provider Grievance Review Panel	A committee consisting of management level subject matter experts who will review and reach a determination for all requested hearings. The individuals on this panel will vary by case review.
Resolved/Resolution	The Grievance has reached a final conclusion with respect to the Member's submitted Grievance and there are no Pending Member appeals within the CalOptima Health Covered Grievance system, including any entities with delegated authority.
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 Covered Programs.

Term	Definition
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health Covered or CalOptima Health Covered Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DMHC. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Third-Party Administrator (TPA)	An individual or entity that has a written agreement with CalOptima Health Covered to perform certain functions and tasks relating to, and necessary for, the delivery of Covered Services.

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For 20261001 BOD Review Only



Policy: CC.1200
Title: **Member Appeal Process**
Department: Grievance and Appeals Resolution Services
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2027
Revised Date: Not Applicable

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

I. PURPOSE

This policy describes the process by which CalOptima Health's Grievance system reviews, addresses, and resolves standard and ~~expedited~~ Expedited pre-service and post-service, Member Appeals of ~~Adverse Benefit Determinations, which also includes the delay, modification, or denial of services based on Medical Necessity or determinations that requested services are not a covered benefit.~~

II. POLICY

~~A. CalOptima Health shall establish and maintain an Appeal Process pursuant to applicable statutory, regulatory, and contractual requirements.~~

A. CalOptima Health shall establish and maintain a Grievance system pursuant to applicable federal and state laws and regulations, including the Knox-Keene Act and its implementing regulations. CalOptima Health's Grievance system is composed of the Appeal Process outlined in this policy and the Grievance Process outlined in CalOptima Health Policy CC.1201: Member Grievance. The Grievance Process outlines CalOptima Health's process for resolving Grievances that do not involve Medical Necessity determination or coverage decisions. The Appeal Process applies to standard and expedited pre-service and post-service Appeals, which are a subset of Grievances that involve medical necessity determinations and coverage decisions. Both the Appeal and Grievance Processes receive and resolve "Grievances", as that term is used under the Knox-Keene Act in accordance with the requirements therein.

B. CalOptima Health's Appeal Process, shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

~~B.C.~~ A Member, or a Provider or Authorized Representative acting on behalf of the Member with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this policy.

1. Members that are minors, incompetent, or incapacitated may have an Appeal requested on their behalf by a Relative, guardian, conservator, or other representative of the Member, as appropriate.

2.—A Member may be represented by anyone they choose during the Appeal Process, including an Authorized Representative. A Member, or the Member's Authorized Representative, may authorize a Provider to assist the Member in submitting the Grievance to DMHC and advocate on behalf of the Member. A Member shall not be financially responsible for the Independent Medical Review (IMR) application or processing fees of any kind.

C. CalOptima Health's Appeal Process shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.

2.

D. CalOptima Health shall assist a Member ~~requiring assistance with filing an Appeal~~, including but not limited to a Member with Limited English Proficiency (LEP), disabilities, or cultural needs ~~and in filing an Appeal~~ in accordance with ~~Section II.R.1.a.c. of this policy~~ CalOptima Health Policy DD.2002: Cultural and Linguistic Services. CalOptima Health shall provide language assistance to Members, by CalOptima Health staff or language line ~~interpreter~~ Interpreter services, for Threshold Languages to register and resolve Appeals.

E. CalOptima Health shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.

~~D.A.~~

~~E.A. CalOptima Health shall ensure prompt review and investigation of an Appeal. A Health Network may participate in the review and investigation of an Appeal.~~

F. Subject to the provisions of this policy, CalOptima Health shall resolve a standard Appeal ~~request~~ within thirty (30) days after receipt of the Appeal, regardless of whether an oral Appeal is followed by a written Appeal.

G. Subject to the provisions of this policy, CalOptima Health shall resolve an Expedited Appeal no later than three (3) days after receipt of such Appeal ~~request~~.

H. CalOptima Health shall refer all Appeals related to medical quality of care issues to the Quality Improvement (QI) Department for review by CalOptima Health's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process, in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

I. For Appeals involving denial of therapy, medical service, or claim for ~~urgent~~ Urgent and Emergency Service based in whole or in part on a finding that the services were not Medically Necessary or were experimental or investigational, a Member has a right to submit the Appeal to the Department of Managed Health Care (DMHC) for an ~~IMR~~ Independent Medical Review (IMR).

1. CalOptima Health shall inform a Member during the Appeal Process of their right to request an IMR, in accordance with Section III.C.2.g.ix. of this policy.

2. A Member shall not be financially responsible for the IMR application or processing fees of any kind.

+

- J. For Appeals involving the denial, to a Member with a Terminal Illness, for treatment, services, or supplies deemed experimental, as recommended by a participating plan Provider:
1. CalOptima Health shall provide the Member, within thirty (30) days, or within five (5) business days if the treating participating physician determines, after consultation with the CalOptima Health medical director or its Designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by CalOptima Health, would be materially reduced if not provided at the earliest possible date.
 2. ~~At~~ CalOptima Health shall provide an opportunity to attend a conference, to review the information provided to the Member pursuant to CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.
 3. The conference shall be conducted by a CalOptima Health representative who has authority to determine the disposition of the Appeal.
 4. CalOptima Health shall allow attendance, in person, at the conference, by a Member, a Designee of the Member, or both, or, if the Member is a minor or incompetent, the parent, guardian, or conservator of the Member, as appropriate.
- K. Continuation of Services during Appeal Process
1. CalOptima Health or a Health Network shall ~~also~~ pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal or IMR was Pending.
- L. Neither CalOptima Health, nor any of its Health Networks, or other Providers shall discriminate against a Member, or a Provider or Member's Authorized Representative on the grounds that they filed an Appeal, in accordance with CalOptima Health Policy HH.1104: Discrimination and TGI-Related Grievances.
- M. The Member Appeal Process set forth in this policy is ~~a separate process from the part of CalOptima Health's Grievance system which also consists of the~~ Member Grievance Process in CalOptima Health Policy CC.1201: Member Grievance. ~~It, but is also separate from the~~ Provider ~~processes~~ complaint process in CalOptima Health Policy ~~HH.1104~~ CC.1202: CalOptima Health Covered Provider Complaint.
- N. CalOptima Health and a Health Network shall provide the CalOptima Health Grievance and Appeal system requirements to its Providers, subcontractors and downstream subcontractors at the time they enter into a subcontract, on an annual basis, and when CalOptima Health's relevant Grievance and Appeals policies and procedures are updated. Any changes to CalOptima Health's Grievance and Appeals policies and procedures shall be communicated ~~to its Providers, subcontractors and downstream subcontractors~~ in accordance with CalOptima Health Policy EE.1103: Provider Network Training.
- O. A Provider may request an Appeal on their own behalf within one hundred eighty (180) days after receipt of the denial for authorization or payment for services already received by the Member, in accordance with CalOptima Health Policy ~~HH.1104~~ CC.1202: CalOptima Health Covered Provider Complaint.
- P. A Provider, with the Member's written consent, may request an Appeal on behalf of the Member for services rendered to that Member by submitting a written request to CalOptima Health within one hundred eighty (180) days from the date of the ~~Notice of Adverse Benefit Determination/Notice of~~

~~Action (NABD/NOA)service denial notice~~ from CalOptima Health or a Health Network, in accordance with the provisions of this policy.

- Q. CalOptima Health shall give a Member, or a Provider, or Authorized Representative acting on behalf of the Member and with the Member's written consent, a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and ~~law in support of the Appeal~~. CalOptima Health shall inform the Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, of the limited time available to present evidence sufficiently in advance of the Resolution timeframes, including for Expedited Appeal.

~~1. Resolution timeframes are as follows:~~

Appeal Request Type	Timeline Requirements	Extension
Standard Pre-Service	Thirty (30) calendar days	N/A
Standard Post-Service	Thirty (30) calendar days	N/A
Expedited Pre-Service	Three (3) calendar days	N/A
Expedited Post-Service	Three (3) calendar days	N/A

- R. CalOptima Health and its Health Networks shall provide culturally and linguistically appropriate notices ~~of, regarding~~ the Appeals Process, ~~Acknowledgement Letters, and Resolution Letters~~ to Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services, including ~~but not limited to, Acknowledgement Letters and Notices of Appeal Resolution;~~

1. ~~CalOptima Health shall provide~~Providing assistance to Members or a Member's Authorized Representative with disabilities, limited English proficiency, vision disorders, or other communicative impairments, when completing Appeal forms and other procedural steps, including but not limited to, providing all documents relied on for CalOptima Health's decision to the Member, in addition to the following services in accordance with CalOptima Health Policy DD.2002; Cultural and Linguistic Services:
 - a. Alternative formats (as set forth in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services);
 - b. Providing auxiliary aids and services upon request, such as ~~interpreter~~Interpreter services and a toll-free number with TTY/TDD and ~~interpreter~~Interpreter capability; and
 - c. Assistance in the Appeal Process or provide translation of Appeal correspondence.

~~S. A Member may be represented by anyone they choose during the Appeal Process, including an Authorized Representative. A Member, or the Member's Authorized Representative, may authorize a Provider to assist the Member in submitting the Grievance to DMHC and advocate on behalf of the Member.~~

~~T.S.~~ The Member has the right to request an Appeal in the event CalOptima Health or a Health Network fails to issue ~~an NABD/NOA~~a notice of service denial/approval within the required time

frame, which shall be considered a denial ~~and therefore constitutes an Adverse Benefit Determination.~~

~~U.T.~~ CalOptima Health shall provide, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, before and during the Appeals Process, the opportunity to examine and/or obtain a copy of the Member's case file, including Medical Records, and any other relevant documents and records considered during the Appeals Process. CalOptima Health shall provide records at no cost.

~~V.U.~~ CalOptima Health shall ensure that the person reviewing the Appeal was not involved in the initial determination and they are not the subordinate of any person involved in the initial determination.

~~W.V.~~ CalOptima Health shall ensure that for Appeals, the person making the final decision for the proposed Resolution of an Appeal has not participated in any prior decisions related to the Appeal. Only qualified health care and licensed professionals with clinical expertise in treating a Member's condition or disease shall make the final determinations for all Appeals. Fiscal and administrative concerns shall not unduly influence the independence of the medical decision-making process.

~~X.W.~~ All Medical Necessity Appeals are referred to the CMO or to their Designee who has the authority to require corrective action and is of the same or similar specialty, has clinical expertise in treating the Member's condition or disease, and is able to treat complications that may result from the service or procedure, if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity or experimental/clinical investigation; and
2. Any Appeal involving clinical issues.

~~Y.X.~~ Upon notice of a CalOptima Health decision to delay, modify, or deny an authorization request based on lack of Medical Necessity, a Member, or a Provider or Authorized Representative acting on behalf of the Member, and with the Member's written consent, may request an Expedited Appeal in accordance with Section III.DC.3. of this policy, when it is determined or the requesting Provider indicates that ~~taking the time for a standard Resolution could seriously jeopardize the case involves an imminent and serious threat to the Member's health of the patient, including, but not limited to, severe pain, potential loss of life, physical limb, or mental health, or ability to attain, maintain, or regain maximum major bodily~~ function.

~~Z.~~ CalOptima Health and a Health Network shall provide the CalOptima Health Grievance and Appeal system requirements to subcontractors at the time they enter into a subcontract, on an annual basis, and when CalOptima Health's relevant Grievance and Appeals policies and procedures are updated.

~~AA.Y.~~ In addition to any rights set forth in this policy, a Member or a Member's Authorized Representative shall also have the right to:

1. Request a standard or ~~expedited~~ Expedited IMR by DMHC.
2. CalOptima Health shall inform a Member of such IMR rights upon enrollment, annually, ~~and in every Notice of Appeal Resolution (NAR) letter in the Evidence of Coverage (EOC), Member Handbook, and in every service denial notice or grievance or appeal correspondence, including Acknowledgment and Resolution letters.~~
3. If CalOptima Health fails to provide adequate notice to a Member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, within

applicable federal or state timeframes, and in accordance with CalOptima Health Policy: DD.2002: Cultural and Linguistic Services, then the Member is deemed to have exhausted CalOptima Health's internal Appeal Process and may immediately request an IMR.

Z. CalOptima Health shall be available twenty-four (24) hours a day, seven (7) days a week to receive communications from the DMHC regarding Urgent Grievances/Expedited Appeals.

1. During normal work hours, CalOptima Health shall respond to the DMHC within thirty (30) minutes after initial contact and within one (1) hour during non-work hours.
2. CalOptima Health has designated representatives, including back-up representatives as necessary, who have the authority to resolve Urgent Grievances/Expedited Appeals and authorize the provision of health care services in a medically appropriate and timely manner. Such authority includes making financial decisions for expenditure of funds on behalf of CalOptima Health without first having to obtain approval from supervisors or other superiors; however, the representative may consult with other plan staff on Urgent Grievances/Expedited Appeals.
3. If CalOptima Health revises the staffing plan for DMHC to be able to contact a representative regarding Urgent Grievances/Expedited Appeals, it shall notify the DMHC at least thirty (30) days in advance of implementing the revisions.

BB-AA. Responsible staff

1. CalOptima Health's Chief Operating Officer shall have primary responsibility for:
 - a. Maintenance of the Appeal Process;
 - b. Review of the operations; and
 - c. Review of any emerging patterns of Appeals in the formulation of policy changes and procedural improvements to CalOptima Health's administration of the program.
2. CalOptima Health's Director of Grievance and Appeals Resolution Services (GARS) shall have primary responsibility for the oversight of the Appeal Process.

BB. The Plan's Grievance system, including its Appeal Process, shall comply with the requirements outlined in CalOptima Health Policy CC.1201: Member Grievance, Section II.U.

III. PROCEDURE

A. Assistance to Members

1. CalOptima Health and a Health Network shall make Grievance and Appeal forms and procedures for filing an Appeal available to Providers and facilities that provide Covered Services to Members and shall require that Providers and facilities promptly provide those forms to a Member upon request.
2. CalOptima Health shall provide the Grievance and Appeal forms and procedures to a Member upon request, shall maintain copies on its website, and make Grievance and Appeals forms and procedures available at each CalOptima Health facility.

- 1 3. CalOptima Health's Customer Service Department shall assist a Member with questions
2 regarding the procedures for filing an Appeal and shall triage Member calls and route Appeals
3 to GARS via an electronic system.
4

5 B. Request for a Pre-Service Appeal (Standard and Expedited)
6

- 7 1. A CalOptima Health Member, or a Provider or Authorized Representative acting on behalf of a
8 Member, and with the Member's written consent, may request a standard or Expedited Appeal
9 within one hundred eighty (180) days from the date of ~~the NABD/NOA~~ a service denial
10 letter/Grievance determination from CalOptima Health or a Health Network orally or in writing
11 by the following methods:
12

- 13 a. Make a request to CalOptima Health's Customer Service Department, by telephone, or in
14 person; or
15
16 b. Make a request to CalOptima Health GARS, by facsimile, in writing, or through the
17 CalOptima Health Website at www.caloptima.org.
18

19 C. Pre-Service Appeal ~~Processing~~ Process (Standard and Expedited)
20

21 ~~1. Standard and Expedited Pre-Service Appeal Processing~~
22

23 ~~a.1.~~ Upon receipt of a request for Appeal, GARS shall:
24

- 25
26 ~~i.a.~~ Date stamp and document the substance of the Appeal, and any action taken, in the GARS
27 database, verifying demographics, and network affiliation.
28

- 29 ~~ii.b.~~ Determine the category of Appeal (coverage dispute, ~~medical necessity~~ Medical Necessity,
30 non-coverage Appeal, or other) ~~based on the Appeal,~~ assign type and subtype descriptors,
31 the responsible staff, and documentation of issue(s).
32

33 ~~b. GARS staff shall review and immediately process Expedited Appeals and issue the decision~~
34 ~~within three (3) days of receipt. CalOptima Health shall provide oral notice of the Resolution of an Expedited~~
35 ~~Appeal and provide the Member and DMHC with a written statement on the disposition or Pending status of the~~
36 ~~Urgent Grievance within three (3) days of receiving the Grievance.~~
37

38 ~~c. Expedited Appeals do not require Acknowledgement Letters as the Resolution letter is~~
39 ~~mailed within three (3) days of receipt date and time. The Resolution letter shall contain the~~
40 ~~same information required for standard Grievances in accordance with CalOptima Health Policy~~
41 ~~CC.1201: Member Grievance.~~
42

43 ~~d. If CalOptima Health extends the timeframe for an Expedited Appeal determination by~~
44 ~~denying the request for an Expedited Appeal, then GARS staff shall notify the Member as~~
45 ~~follows:~~
46

47 ~~i. Verbal Notification: Notify the appealing party and all involved parties of the decision~~
48 ~~to extend the timeframe for an Appeal determination, verbally, no later than one (1)~~
49 ~~business day of such decision; and~~
50

51 ~~ii.i. Written Notification: Notify the Member of the decision, in writing, no later than two~~
52 ~~(2) days of the verbal notice and include:~~

~~a. The reason for the extension; and,~~
c. If CalOptima Health determines, or when the Member or Provider indicates, that taking the time for a standard Resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, or a Provider or Member's Authorized Representative acting on behalf of the Member and with the Member's written consent may request an Expedited Appeal in accordance with Section III.C.3 below of this policy.

~~b. The Member's right to file a Grievance, in accordance with CalOptima Health Policy CC.1201: Member Grievance, if they disagree with CalOptima Health's decision to extend the timeframe.~~

2. Standard Pre-Service Appeal ~~Processing~~Process. For standard Appeals, GARS staff shall:

a. If the Appeal request was made by the Member orally, send a written confirmation of the oral Appeal for the Member's signature. The date of the oral Appeal establishes the filing date for the Appeal, and GARS staff shall process the Appeal regardless of whether a signed written Appeal request ~~is received subsequently~~ from the Member is received or not.

b. ~~GARS staff shall send~~Send a Member, or a Provider or Authorized Representative, acting on behalf of the Member and with the Member's written consent, an Acknowledgment Letter within five (5) days after receipt of an Appeal, that includes the following information:

i. An acknowledgement that the Appeal was received;

~~i. An acknowledgement that the Appeal was received;~~

ii. The date the Appeal was received;

~~iii.~~iii. The name, telephone number, and address of the GARS staff member who may be contacted regarding the Appeal;

~~iii.~~iv. An estimated completion date of Resolution; and

~~iv.~~v. Notice that the appealing party may submit additional information (written or in person) and/or request to review or obtain a copy of the records in connection with the Appeal.

~~c. GARS staff shall send a written confirmation of the oral Appeal for Member's signature, in instances of an oral Appeal request made by the Member.~~

~~i. The date of the oral Appeal establishes the filing date for the Appeal.~~

~~d.~~c. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Appeal.

~~e.d.~~ Ensure an appeals nurse specialist in CalOptima Health's GARS investigates the Appeal, including any aspects of clinical care involved, by:

- i. Reviewing the initial decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records, or other information supplied by a Provider or Member without regard to whether such information was submitted or considered in the initial action;
- ii. Obtaining and reviewing the Health Network's initial decision and supporting documentation, including relevant Medical Records; and
- iii. Preparing the case file for review by CalOptima Health's CMO or their Designee.

~~f.e.~~ CalOptima Health shall utilize specialist consultants, as appropriate.

~~g.f.~~ Escalate the Appeal for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Health Policy HH.1109: Complaint Decision Matrix and shall issue a decision with respect to the Appeal.

~~h.g.~~ Send the Member a ~~NAR letter~~ Resolution Letter within thirty (30) days after receipt of the Appeal. That includes:

~~i. The NAR letter shall describe~~ A description of the Appeal, and provide a the Resolution;

~~ii. A clear and concise explanation of the reasons for the decision, including, but not limited to;~~

~~iii. The results of date~~ The Resolution and the date it was completed;

~~iv. If CalOptima Health upholds a denial determination that is based in whole or in part on Medical Necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination; and notice that the determination may be considered by the DMHC's IMR system;~~

~~v. If CalOptima Health upholds a denial based on a determination that the requested service is not a covered benefit, it shall include the provision in the CalOptima Health plan contract, evidence of coverage, or Member handbook that excludes the service and identify the document and page or section containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specified service or benefit requested;~~

~~vi. If CalOptima Health overturns the denial determination, a clear and concise explanation of why the decision was overturned;~~

~~vii. Any referrals to the QI Department for quality of care review;~~

~~viii. Alternative resources or references, when applicable; and~~

~~ix. The Information about DMHC's IMR process and an, including:~~

~~a. An~~ application with instructions for submitting an IMR request, including the DMHC's toll-free telephone number for further information, and an envelope

addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

b. CalOptima Health shall include on the form any information required by the DMHC to facilitate the completion of the IMR, such as the Member's diagnosis or condition, the nature of the Disputed Health Care Service sought by the Member, a means to identify the Member's case, and any other material information).
CalOptima Health will also include a copy of DMHC's physician certification form using the DMHC Physician Certification Experimental/ Investigational Denials (DMHC/IMR 110-11/27/00) and inform the Member that the certification from the Member's treating physician must include the information required by 28 CCR § 1300.70.4(d) for an IMR of experimental and investigational therapies.

c. A statement informing the Member that participation in CalOptima Health's Grievance system is not required prior to seeking IMR.

i.h. Translate ~~NAR letters~~Resolution Letters into Threshold Languages and offer oral interpretation for a ~~NAR letter~~Interpretation for all other languages, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

j.i. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), ~~include~~including a copy of the ~~NAR letter~~Resolution Letter in the electronic file, and ~~document~~documenting any oral notification provided to the Member.

3. Expedited ~~Pre-Service~~ Appeal ~~Processing~~Process

a. If CalOptima Health determines, ~~for a request from a Member~~ pre-service or contemporaneously with the service, or when the Member or Provider indicates, that taking the time for a standard Resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, a Member, or a Provider or Member's Authorized Representative acting on behalf of the Member and with the Member's written consent, may request an the Appeal will be processed as a request for Expedited Appeal to CalOptima Health. Requests for Expedited Appeal shall be processed as follows:

i. A CalOptima Health Member, or a Provider or Member's Authorized Representative acting on behalf of the CalOptima Health Member and with the Member's written consent, may request an Expedited Appeal by contacting CalOptima Health's Customer Service Department by telephone or in-person, or contacting CalOptima Health's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Health Website at www.caloptima.org.

ii. CalOptima Health staff shall immediately inform the Member of:

ii.a) The limited time to present evidence in person or writing to support the Appeal-and immediately notify the Member:

a)b) Of theirTheir right to contact DMHC regarding their Expedited Appeal; (verbally and in writing by sending or providing a hard copy of the Enrollee Grievance Process which describes their Urgent Grievance/Expedited Appeal rights); and

b)c) That there is no requirement for the Member to participate in the CalOptima Health Grievance process prior to applying to DMHC for review of the Expedited Appeal.

d) If a Member submits an Urgent Grievance to the DMHC for expedited review, CalOptima Health shall notify the DMHC before changing or modifying any benefit or services that relates to the Urgent Grievance if the Member or their Authorized Representative objects to the change or modification.

b. Upon receipt of a Member request for an Expedited Appeal, CalOptima Health's CMO or Designee shall review the request to determine if the ~~expedited review criteria is met and shall conduct a medical review, as deemed necessary, based on whether case involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function.~~

i. ~~A delay could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function based on a prudent layperson's judgment; or~~

ii. ~~In the opinion of a Provider with knowledge of the Member's medical condition, a delay would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.~~

c. CalOptima Health shall grant Expedited Appeal requests concerning if the Appeal is:

e.i. Related to admission, continued stay, or other health care services for a Member who has received Emergency Services but has not been discharged from a facility.

d. ~~Expedited Appeals filed~~Filed by a physician ~~shall be processed as expedited~~ without further review.

e. CalOptima Health shall utilize specialist consultants, as appropriate.

f. CalOptima Health ~~shall resolve or process~~ Expedited ~~Appeal as quickly as~~Appeals and issue the medical decision requires but no later than within three (3) days ~~after of receipt.~~ CalOptima Health ~~receives~~shall provide oral notice of the Resolution of an Expedited Appeal and provide the Member and DMHC with a written statement on the disposition or Pending status of the Expedited Appeal request within three (3) days of receiving it.

g. CalOptima Health shall notify a Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, within twenty-four (24) hours, by telephone, and written notice within three (3) days of the oral notice if the Appeal does not meet Expedited Appeal criteria.

i.h. ~~If the Grievance Appeal~~ does not meet the criteria for ~~urgent~~expedited review, CalOptima Health shall notify the Member and DMHC that the Member's case will be processed as a standard Appeal and the Member's right to notify DMHC of the expedited review request.

Expedited Appeals do not require Acknowledgement Letters as the Resolution letter is mailed within three (3) days of receipt date and time.

i.

j. The Appeal Resolution letter shall contain the same information required for standard Grievances in accordance with CalOptima Health ~~shall notify the Member, or a Provider or Authorized Representative acting on behalf of the~~Policy CC.1201: Member Grievance.

k. ~~If CalOptima Health Member withdenies the Member's written consent, of the Expedited Appeal decision through oral notice or in writing within three (3) days after receiving the request for an Expedited Appeal request. CalOptima Health shall provide a written notice within, then GARS staff shall notify the Member as follows:~~

~~h.i. Verbal Notification: Notify the appealing party and all involved parties of the decision, verbally, no later than one (1) business day after oral notice of such decision; and~~

~~ii. Written Notification: Notify the Member of the decision, in writing, no later than two (2) days of the verbal notice and include:~~

~~a) The reason for the denial; and~~

~~b) The Member's right to file a Grievance, in accordance with CalOptima Health Policy CC.1201: Member Grievance, if they disagree with CalOptima Health's denial decision.~~

4. Pre-service Appeals Resolution (Standard and Expedited)

a. Except as otherwise provided in Section III.C.3. of this policy, CalOptima Health shall send to the Member and ~~Providers~~Provider, as appropriate, ~~a NAR~~An Appeal Resolution Letter within thirty (30) days after receipt of the Appeal.

b. If CalOptima Health completely overturns the denial, the letter shall state the decision and the date of the decision. CalOptima Health shall also ensure the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.

c. If CalOptima Health does not completely overturn the denial, the ~~NAR~~Appeal Resolution Letter shall include information including: the title, qualification and specialty of the person making the decision, how the Member or Provider may obtain copies of the Appeal file documentation or criteria used to make the Appeal decision, the Member's right to request a standard or expedited IMR, ~~and the Member's right to have a representative act on their behalf for an Appeal.~~

d. If CalOptima Health upholds a decision involving the delay, denial, or modification of health care services, the ~~NAR~~Appeal Resolution Letter shall include information regarding the title, qualification, and specialty of the person making the decision and the specific reasons for the Appeal decision, in easy-to-understand language, and a reference to the specific criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the Member.

e. If CalOptima Health upholds an Appeal decision for health care services based in whole or in part on findings that the services are not Covered Services, the ~~NAR~~Appeal Resolution Letter shall include information regarding the title of the person making the decision and clearly specify the provisions of the contract that exclude that service, ~~evidence~~Evidence of coverageCoverage or the Member handbook reference for excluded services. The response shall either identify the document and page where the provision is found, direct the Member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear ~~and~~ concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee. The response shall also include a notice that if the Member believes the decision was denied on the grounds that it

1 was not Medically Necessary, the Member may contact the DMHC to determine whether
2 the decision is eligible for IMR.

- 3
4 f. CalOptima Health and a Health Network shall take immediate action to implement the
5 decision as expeditiously as the Member's condition requires and ~~no later than seventy-two~~
6 ~~(72) hours from in accordance with the date of the decision~~ timeframes as required in
7 CalOptima Health Policy GG.1507: Notification Requirements for Services Requiring Prior
8 Authorization.
9

10 D. Post-service Appeal Processing

- 11
12 1. CalOptima Health GARS staff shall obtain all documentation related to the Appeal, including
13 but not limited to any claims submitted on behalf of the Member, Provider information,
14 Member's referral and authorization history, and clinical history documentation on file, as well
15 as any information provided by the Member, Authorized Representative, or Provider.
16
17 2. A GARS Appeals nurse shall investigate, review, and summarize the Appeal history and
18 documentation, including any aspects of clinical care involved, for submission to CMO or their
19 Designee for review.
20
21 3. All medical Appeals are referred to the CMO or their Designee who has the authority to require
22 corrective action, is of the same or similar specialty, is able to treat complications that may
23 result from the service or procedure and did not make the initial utilization management
24 decision.
25
26 4. CalOptima Health shall utilize specialist consultants as appropriate.
27
28 5. Post-service Appeals Resolution
29
30 a. CalOptima Health shall send to the Member and Provider, as appropriate, a NAR Appeal
31 Resolution Letter within thirty (30) days after receipt of the Appeal.
32
33 b. If CalOptima Health completely overturns the decision, the NAR Appeal Resolution Letter
34 shall state the decision and the date of the decision. CalOptima Health shall also ensure the
35 written response sent to the appealing party contains a clear and concise explanation of the
36 reason, including the reason for why the decision was overturned.
37
38 c. If CalOptima Health does not completely overturn the decision, the NAR Appeal Resolution
39 Letter shall include information regarding the name and title of the person making the
40 decision, how the Member or Provider may obtain, upon request, copies of the Appeal file
41 documentation or criteria used to make the Appeal decision; ~~the right to continue to receive~~
42 ~~benefits Pending an IMR, and;~~ the Member's right to request a standard or expedited IMR;
43 ~~in accordance with CalOptima Health Policy HH.1108: State Hearing Process and~~
44 ~~Procedures and the Member's right to have a representative act on their behalf when they~~
45 ~~appeal.~~
46
47 d. If CalOptima Health upholds an Appeal decision, in whole or in part, the NAR Appeal
48 Resolution Letter shall describe the specific reasons for the Appeal decision in easy-to-
49 understand language, a reference to the specific criteria, guideline or protocol used and
50 clinical reasons for the decision as it applies to the Member.
51
52 e. CalOptima Health and a Health Network shall take immediate action to implement the
53 decision as expeditiously as the Member's condition requires and ~~no later than seventy-two~~

~~(72) hours from~~ in accordance with the ~~date~~ timeframes as required in CalOptima Health Policy GG.1507: Notification Requirements for Services Requiring Prior Authorization.

E. Independent Medical Review

1. A Member may apply to the DMHC for an IMR when all of the following conditions are met:

a. One of:

i. The Member's Provider has recommended a health care service as Medically Necessary;

ii. The Member has received Urgent Care or Emergency Services that a Provider determined were Medically Necessary; or

iii. The Member has been seen by a contracted Provider for the diagnosis or treatment of the medical condition for which the Member seeks independent review. CalOptima Health shall expedite access to a contracting Provider upon request of a Member. The contracting Provider need not recommend the Disputed Health Care Service as a condition for the Member to be eligible for IMR. For purposes of the IMR, the Member's Provider may be a noncontracted Provider; however, CalOptima Health shall have no liability for payment of services provided by a noncontracted Provider, except as provided in accordance with Section III.E.6. of this policy.

e.b. The Disputed Health Care Service has been denied, modified, or delayed by CalOptima Health or a Health Network, or by one (1) of its contracted providers, based in whole or in part on a decision that the health care service is not Medically Necessary.

c. The Member has filed an Appeal/Grievance with CalOptima Health or a contracted Provider and the Appeal is upheld or remains unresolved after thirty (30) days. For Expedited Appeals or any other cases where the DMHC determines that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the Member, the Member shall not be required to participate in the Appeal process for more than three (3) days.

d. Any case in which a Member or Provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of Medical Necessity, the DMHC shall have the final authority to determine whether the Grievance/Appeal is more properly resolved pursuant to an IMR or DMHC review of a Grievance. The DMHC shall also have final authority to determine whether a Grievance is a Disputed Health Care Service or a Coverage Decision.

2. A Member may apply to the DMHC for an IMR of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the Disputed Health Care Services are not Medically Necessary, within six (6) months of any of the qualifying periods or events described above, or in cases where the DMHC has determined the circumstances warrant a longer application deadline.

3. If CalOptima Health is notified by DMHC that a ~~Member has requested an IMR~~ that an application for IMR has been assigned to an IMR organization, CalOptima Health shall provide the ~~following organization with all~~ information that was considered in relation to the Disputed Health Care Service, the Member's Grievance, and CalOptima Health's determination. Unless

otherwise advised in the notification or by the assigned review organization, CalOptima Health shall submit a complete set of the materials listed below to the IMR organization within three (3) business days for standard ~~appeals~~ Appeals, or within twenty-four (24) hours for Expedited Appeals, ~~unless otherwise advised in the notification~~:

a. ~~A copy of the Member's~~ A copy of all correspondence from and received by CalOptima Health concerning the Disputed Health Care Service, including any Member Grievance related to the requested service;

b. A complete and legible copy of all Medical Records in possession of and other information used by CalOptima Health and its Health Networks related in making the decision regarding the Disputed Health Care Service. An additional copy of medical records shall be submitted for each reviewer. Copies of Medical Records relevant to the following will be provided:

i. The Member's medical condition, ~~health care~~;

ii. The services ~~being currently~~ provided by CalOptima Health's Providers Health and its Health Networks for the Member's condition; and the

~~1.~~iii. The Disputed Health Care Services Service requested by the Member for the condition.

c. A copy of the cover page of the EOC and complete pages with the referenced sections highlighted or underlined sections, if the EOC was reference in CalOptima Health's Resolution;

d. CalOptima Health's response to any additional issues raised in the Member's application for IMR.

e. CalOptima Health shall promptly provide the Member with an annotated list of all documents submitted to the independent review organization, together with information on how copies may be requested.

~~2.~~f. Any newly developed or discovered relevant Medical Records in possession of CalOptima Health shall be immediately forwarded to the IMR organization and the Member or the Member's Provider, if authorized by the Member, unless the offer of Medical Records is declined or otherwise prohibited by law.

~~3.~~g. Copies of all information CalOptima Health provided to the Member and Providers and Member provided to CalOptima Health concerning the plan and Provider decisions regarding the Member's condition, care, or support of the Disputed Health Care Service, including copies of CalOptima Health's Appeal Resolution ~~letter~~ Letter.

~~4.~~h. Copies of any other relevant documents or information used by CalOptima Health or its Providers in determining whether the Disputed Health Care Service should be provided, and any statements explaining the reasons for the decision to deny, modify, or delay Disputed Health Care Services on the basis of medical necessity.

~~5.~~4. The confidentiality of all Medical Record information and medical information provided outside of the Medical Record shall be maintained pursuant to applicable state and federal laws.

5. CalOptima Health shall also provide additional information as follows:

2. Any Medical Records or other relevant matters not available at the time of the DMHC's initial notification, or that result from the Member's ongoing medical care or treatment for the medical condition or disease under review. Such matters shall be forwarded as soon as

possible upon receipt by CalOptima Health, not to exceed five (5) business days in routine cases or one (1) calendar day in expedited cases.

3. Additional Medical Records or other information requested by the IMR organization shall be sent within five (5) business days in routine cases or one (1) calendar day in expedited cases. In expedited reviews, CalOptima Health shall immediately notify the Member and the Member's Provider by telephone or facsimile to identify and request the necessary information, followed by written notification, when the request involves materials not in CalOptima Health's or its contracting Providers' possession.

~~F.6.~~ Upon notification that DMHC, through the IMR process, has ruled a Disputed Health Care Service as Medically Necessary, CalOptima Health will immediately contact the Member and arrange to authorize the services as expeditiously as the Member's health condition requires.

~~1.a.~~ In the case of reimbursement for services already rendered, CalOptima Health shall reimburse the Provider or Member, whichever applies, within five (5) business days.

~~2.b.~~ In the case of services not yet rendered, CalOptima Health shall authorize the services within five (5) business days of receipt of the written decision from the DMHC, or sooner if appropriate for the nature of the Member's medical condition and shall inform the Member and Provider of the authorization in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

~~c.~~ In the case of an external exception request for pharmacy related Appeals that is deemed by the DMHC to be Medically Necessary, CalOptima Health will facilitate authorization as expeditiously as the Member's health condition requires, not to exceed seventy-two (72) hours.

~~d.~~ CalOptima Health shall promptly reimburse the Member for any reasonable costs associated with services where:

~~i.~~ The DMHC finds that the Disputed Health Care Services were a covered benefit under the terms and conditions of the CalOptima Health plan contract;

~~ii.~~ The services are found by the IMR organization to have been Medically Necessary; and

~~iii.~~ Either the Member's decision to secure the services outside of the CalOptima Health provider network was reasonable under the Emergency or Urgent medical circumstances, or the CalOptima Health plan contract does not require or provide prior authorization for those health care services.

~~G.~~ An any DMHC review of a Grievance involving a Disputed Health Care Service that is not eligible for IMR in which the DMHC finds that CalOptima Health has delayed, denied, or modified health care services that are Medically Necessary, based on the specific medical circumstances of the Member, and those services are a covered benefit under the terms and conditions of the CalOptima Health plan contract, CalOptima Health shall comply with DMHC's binding order and written notice to:

~~1.~~ Promptly offer and provide health care services to the Member; or

~~3-2.~~ Promptly reimburse the Member for any reasonable costs associated with Urgent Care or Emergency Services, or other extraordinary and compelling health care services, when the DMHC finds that the Member's decision to secure those services outside of the plan

network was reasonable under the circumstances.

F.H. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, related procedures regarding the Grievance Process, information regarding DMHC review process, the IMR system, and the DMHC's toll-free telephone number and website address. CalOptima Health shall provide these notices in Threshold Languages, as required by DMHC and Covered California.
2. CalOptima Health shall keep in its files written records of each Appeal, including copies of Appeal records of any sub-contracting entity delegated the responsibility to maintain and resolve Appeals. The records shall include all Medical Records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision, the date and time of receipt, Member's name, description of the complaint or problem, names of the CalOptima Health staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, Resolution proposed by GARS or the medical professional responsible for making utilization management decision, the name of the CalOptima Health Provider or staff responsible for resolving the Appeal, the date of notification to the Member of Resolution, and all Appeal Resolution letters. CalOptima Health shall maintain the written records, for a minimum of ten (10) years.
3. CalOptima Health shall continually evaluate and analyze Appeal data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.
4. CalOptima Health shall submit, on a quarterly basis, aggregated and detailed Appeals data to the Quality Assurance Committee.
5. CalOptima Health shall establish and maintain a system of aging of Appeals that are Pending and unresolved for thirty (30) days or more. The system shall also track and monitor Appeals received and resolved, including the number received and resolved, whether each Appeal was resolved in favor of the member or CalOptima Health, the number pending more than thirty (30) days, the applicable product category, and the status and location of pending Appeals.
6. Aging Grievances Report. CalOptima Health's Grievance system shall track and document aging Grievances, which are Grievances that are Pending and unresolved for thirty (30) days or more, and shall include Appeals. The Grievance system shall also categorize tracked Grievances and Appeals by type, including, as applicable, coverage disputes, Medical Necessity disputes, quality of care, access to care, quality of service, and other issues. CalOptima Health shall provide a quarterly report to DMHC of Grievances Pending and unresolved for thirty (30) or more days. The report shall be verified by CalOptima Health's Director of Grievance and Appeals Resolution Services and submitted as specified in Section G of CalOptima Health Policy CC.1201: Member Grievance, Title 28, California Code of Regulations § 1300.68(i), and Department of Managed Health Care All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8, 2022).
7. The written record of Appeals shall be reviewed periodically by CalOptima Health's Governing Board, the Member Advisory Committee, and Provider Advisory Committee and the Chief Operating Officer or Designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

- a. GARS shall present to the ~~QIHEC~~ Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Health and Safety Code §§ 1365, 1367.01(e),(h)(3), and (j), 1368 (a)(1), (a)(4)(B), 1368.01(a)-(b), 1368.016, 1368.02(b), 1367.24, 1368.015, 1370.2, 1371.34, 1374.30 (e), (i), (j)(1) and (3) (l), (m), (n), 1374.31, 1374.34(a).
- B. CalOptima Health Appeal Acknowledgement Letter
- C. CalOptima Health Appeal Resolution Letter – Overturn
- D. CalOptima Health Appeal Resolution Letter – Uphold
- E. CalOptima Health Expedited Appeal Acknowledgement (Downgrade) Letter
- ~~B.F.~~ CalOptima Health Contract with Covered California
- G. CalOptima Health Language Assistance Taglines
- H. CalOptima Health Member Complaint Form
- I. CalOptima Health Member Grievance Process
- J. CalOptima Health Member Non-discrimination Notice
- ~~C.K.~~ CalOptima Health Policy CC.1201: Member Grievance
- L. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint
- ~~D.M.~~ CalOptima Health Policy DD.2002: Cultural and Linguistic Services
- ~~E.N.~~ CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
- ~~F.O.~~ CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
- ~~G.P.~~ CalOptima Health Policy HH.1104: Discrimination and TGI-Related Grievances
- ~~H.~~ CalOptima Health Policy HH.1108: State Hearings Process and Procedures
- ~~I.Q.~~ CalOptima Health Policy HH.1109: Complaint Decision Matrix
- ~~J.R.~~ Department of Managed Health Care All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8, 2022)
- ~~K.S.~~ Standards and Guidelines for the Accreditation of Health Plans
- ~~L.T.~~ Title 28, California Code of Regulations (C.C.R.), §§ 1300.68(a), (a), (b)(3)-(b)(8), 1300.85, 1300.85.01-
- ~~M.U.~~ Title 45, Code of Federal Regulations (C.F.R.), § 156.122(c)-)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1200	Member Appeal Process	Covered California

For 20261001 BOD Review Only

IX. GLOSSARY

Term	Definitions
Acknowledgement Letter	A written statement acknowledging receipt of an Appeal.
Adverse Benefit Determination <u>Appeal</u>	AnyA type of Grievance related to <u>any</u> of the following <u>Medical Necessity determination or coverage</u> actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability.
<u>Appeal Acknowledgement/Resolution Letter</u>	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 required in this policy. <u>A written statement acknowledging receipt of, or resolving, an Appeal.</u>
Appeal Process	The process by which CalOptima Health and its Health Networks address and provide Resolution to all Appeals.

Term	Definitions
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 DHCS State Fair Hearings, 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.
<u>Coverage Decision</u>	<u>Covered California: The approval or denial of health care services by CalOptima Health or a Health Network substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Member's CalOptima plan contract. A "coverage decision" does not encompass a CalOptima Health or Health Network decision regarding a disputed health care service.</u>
Covered Service	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.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations -and other managed care plans.
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.
Disputed Health Care Service	Any health care service eligible for coverage and payment under a CalOptima Health plan contract that has been denied, modified, or delayed by a decision of CalOptima Health, or by one of its contracting Providers, in whole or in part due to a finding that the service is not Medically Necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a coverage decision.
Emergency Services	<u>In cases involving a claim for out of plan emergency services that a Provider determined were Medically Necessary to screen and stabilize the Member's condition, emergency services are services for emergency medical conditions as defined in Title 28 of the California Code of Regulations § 1300.71.4 where the Member has obtained the services without prior authorization from CalOptima Health or from a contracting Provider. Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in and Health & Safety Code § 1317.1(a)(1) and §1317(a)(2)(A).</u>
Expedited Appeal	A type of Urgent Grievance involving an Adverse Benefit Determination . <u>Appeal.</u>

Term	Definitions
Governing Board	CalOptima Health's Board of Directors or a similar body, and/or its executive management, that has the authority to manage and direct CalOptima Health's affairs and activities, including, but not limited to, approving initiatives and establishing CalOptima Health's policies and procedures.
Grievance/ <u>Grievant</u>	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. <u>A Grievant is the individual making or filing the Grievance.</u>
<u>Grievance Process</u>	<u>The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.</u>
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.
Independent Medical Review (IMR)	A review of CalOptima Health's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on CalOptima Health pursuant to Health and Safety Code § 1374.30 and Title 28 California Code of Regulations §1300.74.30.
<u>Interpret/Interpretation</u>	<u>The act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).</u>
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.

Term	Definitions
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).
Member	An individual enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Pending	Grievances or Appeals that are not resolved within thirty (30) days, or that are referred to the DMHC's complaint or independent medical review system or other external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, as applicable.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
Relative	A parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member.
Resolved/Resolution	The Grievance has reached a final conclusion with respect to the Member's submitted Grievance and there are no Pending Member appeals within CalOptima Health's Grievance system, including any entities with delegated authority.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.
<u>Urgent Care</u>	<u>Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the plan's service area.</u>

Term	Definitions
Urgent Grievance	Grievances that involve an imminent and serious threat to the mental or physical health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

1
2

For 20261001 BOD Review Only



Policy: CC.1200
Title: **Member Appeal Process**
Department: Grievance and Appeals Resolution Services
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2027
Revised Date: Not Applicable

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

I. PURPOSE

This policy describes the process by which CalOptima Health's Grievance system reviews, addresses, and resolves standard and Expedited pre-service and post-service Member Appeals Determinations.

II. POLICY

- A. CalOptima Health shall establish and maintain a Grievance system pursuant to applicable federal and state laws and regulations, including the Knox-Keene Act and its implementing regulations. CalOptima Health's Grievance system is composed of the Appeal Process outlined in this policy and the Grievance Process outlined in CalOptima Health Policy CC.1201: Member Grievance. The Grievance Process outlines CalOptima Health's process for resolving Grievances that do not involve Medical Necessity determination or coverage decisions. The Appeal Process applies to standard and expedited pre-service and post-service Appeals, which are a subset of Grievances that involve medical necessity determinations and coverage decisions. Both the Appeal and Grievance Processes receive and resolve "Grievances", as that term is used under the Knox-Keene Act in accordance with the requirements therein.
- B. CalOptima Health's Appeal Process, shall address the receipt, handling, and disposition of a Member's Appeal, in accordance with applicable statutory, regulatory, and contractual requirements.
- C. A Member, or a Provider or Authorized Representative acting on behalf of the Member with the Member's written consent, has the right to file an Appeal in the timeframes set forth in this policy.
1. Members that are minors, incompetent, or incapacitated may have an Appeal requested on their behalf by a Relative, guardian, conservator, or other representative of the Member, as appropriate.
 2. A Member may be represented by anyone they choose during the Appeal Process, including an Authorized Representative. A Member, or the Member's Authorized Representative, may authorize a Provider to assist the Member in submitting the Grievance to DMHC and advocate on behalf of the Member.

- 1 D. CalOptima Health shall assist a Member, including a Member with Limited English Proficiency
2 (LEP), disabilities, or cultural needs in filing an Appeal in accordance with CalOptima Health
3 Policy DD.2002: Cultural and Linguistic Services. CalOptima Health shall provide language
4 assistance to Members, by CalOptima Health staff or language line Interpreter services, for
5 Threshold Languages to register and resolve Appeals.
6
- 7 E. CalOptima Health shall ensure prompt review and investigation of an Appeal. A Health Network
8 may participate in the review and investigation of an Appeal.
9
- 10 F. Subject to the provisions of this policy, CalOptima Health shall resolve a standard Appeal within
11 thirty (30) days after receipt of the Appeal, regardless of whether an oral Appeal is followed by a
12 written Appeal.
13
- 14 G. Subject to the provisions of this policy, CalOptima Health shall resolve an Expedited Appeal no
15 later than three (3) days after receipt of such Appeal.
16
- 17 H. CalOptima Health shall refer all Appeals related to medical quality of care issues to the Quality
18 Improvement (QI) Department for review by CalOptima Health's Chief Medical Officer (CMO) or
19 their Designee and any action deemed necessary under the quality review process, in accordance
20 with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.
21
- 22 I. For Appeals involving denial of therapy, medical service, or claim for Urgent and Emergency
23 Service based in whole or in part on a finding that the services were not Medically Necessary or
24 were experimental or investigational, a Member has a right to submit the Appeal to the Department
25 of Managed Health Care (DMHC) for an Independent Medical Review (IMR).
26
- 27 1. CalOptima Health shall inform a Member during the Appeal Process of their right to request an
28 IMR in accordance with Section III.C.2.g.ix. of this policy.
29
- 30 2. A Member shall not be financially responsible for the IMR application or processing fees of any
31 kind.
32
- 33 J. For Appeals involving the denial, to a Member with a Terminal Illness, for treatment, services, or
34 supplies deemed experimental, as recommended by a participating plan Provider:
35
- 36 1. CalOptima Health shall provide the Member, within thirty (30) days, or within five (5) business
37 days if the treating participating physician determines, after consultation with the CalOptima
38 Health medical director or its Designee, based on standard medical practice, that the
39 effectiveness of either the proposed treatment, services, or supplies or any alternative treatment,
40 services, or supplies covered by CalOptima Health, would be materially reduced if not provided
41 at the earliest possible date.
42
- 43 2. CalOptima Health shall provide an opportunity to attend a conference to review the information
44 provided to the Member pursuant to CalOptima Health Policy GG.1507: Notification
45 Requirements for Covered Services Requiring Prior Authorization.
46
- 47 3. The conference shall be conducted by a CalOptima Health representative who has authority to
48 determine the disposition of the Appeal.
49
- 50 4. CalOptima Health shall allow attendance, in person, at the conference, by a Member, a
51 Designee of the Member, or both, or, if the Member is a minor or incompetent, the parent,
52 guardian, or conservator of the Member, as appropriate.
53

1 K. Continuation of Services during Appeal Process

- 2
3 1. CalOptima Health or a Health Network shall pay for disputed Covered Services if the Member
4 received the disputed Covered Services while the Appeal or IMR was Pending.
5

6 L. Neither CalOptima Health, nor any of its Health Networks, or other Providers shall discriminate
7 against a Member, or a Provider or Member's Authorized Representative on the grounds that they
8 filed an Appeal, in accordance with CalOptima Health Policy HH.1104: Discrimination and TGI-
9 Related Grievances.
10

11 M. The Member Appeal Process set forth in this policy is part of CalOptima Health's Grievance system
12 which also consists of the Member Grievance Process in CalOptima Health Policy CC.1201:
13 Member Grievance, but is separate from the Provider complaint process in CalOptima Health Policy
14 CC.1202: CalOptima Health Covered Provider Complaint.
15

16 N. CalOptima Health and a Health Network shall provide the CalOptima Health Grievance and Appeal
17 system requirements to its Providers, subcontractors and downstream subcontractors at the time they
18 enter into a subcontract, on an annual basis, and when CalOptima Health's relevant Grievance and
19 Appeals policies and procedures are updated. Any changes to CalOptima Health's Grievance and
20 Appeals policies and procedures shall be communicated in accordance with CalOptima Health
21 Policy EE.1103: Provider Network Training.
22

23 O. A Provider may request an Appeal on their own behalf within one hundred eighty (180) days after
24 receipt of the denial for authorization or payment for services already received by the Member, in
25 accordance with CalOptima Health Policy CC.1202: CalOptima Health Covered Provider
26 Complaint.
27

28 P. A Provider, with the Member's written consent, may request an Appeal on behalf of the Member for
29 services rendered to that Member by submitting a written request to CalOptima Health within one
30 hundred eighty (180) days from the date of the service denial notice from CalOptima Health or a
31 Health Network, in accordance with the provisions of this policy.
32

33 Q. CalOptima Health shall give a Member, or a Provider, or Authorized Representative acting on
34 behalf of the Member and with the Member's written consent, a reasonable opportunity to present,
35 in writing or in person, before the individual(s) resolving the Appeal, evidence, testimony, facts, and
36 CalOptima Health shall inform the Member, or a Provider or Authorized Representative, acting on
37 behalf of the Member and with the Member's written consent, of the limited time available to
38 present evidence sufficiently in advance of the Resolution timeframes, including for Expedited
39 Appeal.
40

41 R. CalOptima Health and its Health Networks shall provide culturally and linguistically appropriate
42 notices, regarding the Appeals Process, Acknowledgement Letters, and Resolution Letters to
43 Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services,
44 including:
45

- 46 1. Providing assistance to Members or a Member's Authorized Representative with disabilities,
47 limited English proficiency, vision disorders, or other communicative impairments, when
48 completing Appeal forms and other procedural steps, including but not limited to, providing all
49 documents relied on for CalOptima Health's decision to the Member, in addition to the
50 following services in accordance with CalOptima Health Policy DD.2002; Cultural and
51 Linguistic Services:
52

- 1 a. Alternative formats (as set forth in accordance with CalOptima Health Policy DD.2002:
2 Cultural and Linguistic Services);
3
4 b. Providing auxiliary aids and services upon request, such as Interpreter services and a toll-
5 free number with TTY/TDD and Interpreter capability; and
6
7 c. Assistance in the Appeal Process or provide translation of Appeal correspondence.
8
9 S. The Member has the right to request an Appeal in the event CalOptima Health or a Health Network
10 fails to issue a notice of service denial/approval within the required time frame, which shall be
11 considered a denial.
12
13 T. CalOptima Health shall provide, upon request by the Member, or a Provider or Authorized
14 Representative acting on behalf of the Member and with the Member's written consent, before and
15 during the Appeals Process, the opportunity to examine and/or obtain a copy of the Member's case
16 file, including Medical Records, and any other relevant documents and records considered during
17 the Appeals Process. CalOptima Health shall provide records at no cost.
18
19 U. CalOptima Health shall ensure that the person reviewing the Appeal was not involved in the initial
20 determination and they are not the subordinate of any person involved in the initial determination.
21
22 V. CalOptima Health shall ensure that for Appeals, the person making the final decision for the
23 proposed Resolution of an Appeal has not participated in any prior decisions related to the Appeal.
24 Only qualified health care and licensed professionals with clinical expertise in treating a Member's
25 condition or disease shall make the final determinations for all Appeals. Fiscal and administrative
26 concerns shall not unduly influence the independence of the medical decision-making process.
27
28 W. All Medical Necessity Appeals are referred to the CMO or to their Designee who has the authority
29 to require corrective action and is of the same or similar specialty, has clinical expertise in treating
30 the Member's condition or disease, and is able to treat complications that may result from the
31 service or procedure, if deciding on any of the following:
32
33 1. An Appeal of a denial based on lack of Medical Necessity or experimental/clinical
34 investigation; and
35
36 2. Any Appeal involving clinical issues.
37
38 X. Upon notice of a CalOptima Health decision to delay, modify, or deny an authorization request
39 based on lack of Medical Necessity, a Member, or a Provider or Authorized Representative acting
40 on behalf of the Member, and with the Member's written consent, may request an Expedited Appeal
41 in accordance with Section III.C.3. of this policy, when it is determined or the requesting Provider
42 indicates that the case involves an imminent and serious threat to the health of the patient, including,
43 but not limited to, severe pain, potential loss of life, limb, or major bodily function.
44
45 Y. In addition to any rights set forth in this policy, a Member or a Member's Authorized
46 Representative shall also have the right to:
47
48 1. Request a standard or Expedited IMR by DMHC.
49
50 2. CalOptima Health shall inform a Member of such IMR rights upon enrollment, annually, in the
51 Evidence of Coverage (EOC), Member Handbook, and in every service denial notice or
52 grievance or appeal correspondence, including Acknowledgment and Resolution letters.
53

- 1 3. If CalOptima Health fails to provide adequate notice to a Member with a visual impairment or
2 other disabilities requiring the provision of written materials in alternative formats, within
3 applicable federal or state timeframes, and in accordance with CalOptima Health Policy:
4 DD.2002: Cultural and Linguistic Services, then the Member is deemed to have exhausted
5 CalOptima Health's internal Appeal Process and may immediately request an IMR.
6
7 Z. CalOptima Health shall be available twenty-four (24) hours a day, seven (7) days a week to receive
8 communications from the DMHC regarding Urgent Grievances/Expedited Appeals.
9
10 1. During normal work hours, CalOptima Health shall respond to the DMHC within thirty (30)
11 minutes after initial contact and within one (1) hour during non-work hours.
12
13 2. CalOptima Health has designated representatives, including back-up representatives as
14 necessary, who have the authority to resolve Urgent Grievances/Expedited Appeals and
15 authorize the provision of health care services in a medically appropriate and timely manner.
16 Such authority includes making financial decisions for expenditure of funds on behalf of
17 CalOptima Health without first having to obtain approval from supervisors or other superiors;
18 however, the representative may consult with other plan staff on Urgent Grievances/Expedited
19 Appeals.
20
21 3. If CalOptima Health revises the staffing plan for DMHC to be able to contact a representative
22 regarding Urgent Grievances/Expedited Appeals, it shall notify the DMHC at least thirty (30)
23 days in advance of implementing the revisions.
24
25 AA. Responsible staff
26
27 1. CalOptima Health's Chief Operating Officer shall have primary responsibility for:
28
29 a. Maintenance of the Appeal Process;
30
31 b. Review of the operations; and
32
33 c. Review of any emerging patterns of Appeals in the formulation of policy changes and
34 procedural improvements to CalOptima Health's administration of the program.
35
36 2. CalOptima Health's Director of Grievance and Appeals Resolution Services (GARS) shall have
37 primary responsibility for the oversight of the Appeal Process.
38
39 BB. The Plan's Grievance system, including its Appeal Process, shall comply with the requirements
40 outlined in CalOptima Health Policy CC.1201: Member Grievance, Section II.U.
41

42 **III. PROCEDURE**

43 **A. Assistance to Members**

- 44
45
46 1. CalOptima Health and a Health Network shall make Grievance and Appeal forms and
47 procedures for filing an Appeal available to Providers and facilities that provide Covered
48 Services to Members and shall require that Providers and facilities promptly provide those
49 forms to a Member upon request.
50
51 2. CalOptima Health shall provide the Grievance and Appeal forms and procedures to a Member
52 upon request, shall maintain copies on its website, and make Grievance and Appeals forms and
53 procedures available at each CalOptima Health facility.

- 1
2 3. CalOptima Health's Customer Service Department shall assist a Member with questions
3 regarding the procedures for filing an Appeal and shall triage Member calls and route Appeals
4 to GARS via an electronic system.
5

6 B. Request for a Pre-Service Appeal (Standard and Expedited)
7

- 8 1. A CalOptima Health Member, or a Provider or Authorized Representative acting on behalf of a
9 Member, and with the Member's written consent, may request a standard or Expedited Appeal
10 within one hundred eighty (180) days from the date of a service denial letter/Grievance
11 determination from CalOptima Health or a Health Network orally or in writing by the following
12 methods:
13
14 a. Make a request to CalOptima Health's Customer Service Department, by telephone, or in
15 person; or
16
17 b. Make a request to CalOptima Health GARS, by facsimile, in writing, or through the
18 CalOptima Health Website at www.caloptima.org.
19

20 C. Pre-Service Appeal Process (Standard and Expedited)
21

- 22 1. Upon receipt of a request for Appeal, GARS shall:
23
24 a. Date stamp and document the substance of the Appeal, and any action taken, in the GARS
25 database, verifying demographics, and network affiliation.
26
27 b. Determine the category of Appeal (coverage dispute, Medical Necessity, non-coverage
28 Appeal, or other), assign type and subtype descriptors, the responsible staff, and
29 documentation of issue(s).
30
31 c. If CalOptima Health determines, or when the Member or Provider indicates, that taking the
32 time for a standard Resolution could seriously jeopardize the Member's life or health or
33 ability to maintain, or regarding maximum function, a Member, or a Provider or Member's
34 Authorized Representative acting on behalf of the Member and with the Member's written
35 consent may request an Expedited Appeal in accordance with Section III.C.3 below of this
36 policy.
37
38 2. Standard Pre-Service Appeal Process. For standard Appeals, GARS staff shall:
39
40 a. If the Appeal request was made by the Member orally, send a written confirmation of the
41 oral Appeal for the Member's signature. The date of the oral Appeal establishes the filing
42 date for the Appeal, and GARS staff shall process the Appeal regardless of whether a
43 signed written Appeal request from the Member is received or not.
44
45 b. Send a Member, or a Provider or Authorized Representative, acting on behalf of the
46 Member and with the Member's written consent, an Acknowledgment Letter within five (5)
47 days after receipt of an Appeal that includes the following information:
48
49 i. An acknowledgement that the Appeal was received;
50 ii. The date the Appeal was received;
51 iii. The name, telephone number, and address of the GARS staff member who may be
52 contacted regarding the Appeal;
53

- iv. An estimated completion date of Resolution; and
- v. Notice that the appealing party may submit additional information (written or in person) and/or request to review or obtain a copy of the records in connection with the Appeal.
- c. Triage and investigate the Appeal, and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Appeal.
- d. Ensure an appeals nurse specialist in CalOptima Health's GARS investigates the Appeal, including any aspects of clinical care involved, by:
 - i. Reviewing the initial decision and all documents related to the determination of Medical Necessity of the service requested, including any additional comments, documents, records, or other information supplied by a Provider or Member without regard to whether such information was submitted or considered in the initial action;
 - ii. Obtaining and reviewing the Health Network's initial decision and supporting documentation, including relevant Medical Records; and
 - iii. Preparing the case file for review by CalOptima Health's CMO or their Designee.
- e. CalOptima Health shall utilize specialist consultants, as appropriate.
- f. Escalate the Appeal for review of the factual findings, proposed Resolution, and any other relevant information, in accordance with CalOptima Health Policy HH.1109: Complaint Decision Matrix and shall issue a decision with respect to the Appeal.
- g. Send the Member a Resolution Letter within thirty (30) days after receipt of the Appeal That includes:
 - i. A description of the Appeal and the Resolution;
 - ii. A clear and concise explanation of the reasons for the decision;
 - iii. The date the Resolution was completed;
 - iv. If CalOptima Health upholds a denial determination that is based in whole or in part on Medical Necessity, it shall include the reasons for the decision and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination and notice that the determination may be considered by the DMHC's IMR system;
 - v. If CalOptima Health upholds a denial based on a determination that the requested service is not a covered benefit, it shall include the provision in the CalOptima Health plan contract, evidence of coverage, or Member handbook that excludes the service and identify the document and page or section containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specified service or benefit requested;
 - vi. If CalOptima Health overturns the denial determination, a clear and concise explanation of why the decision was overturned;
 - vii. Any referrals to the QI Department for quality of care review;

viii. Alternative resources or references, when applicable; and

ix. Information about DMHC's IMR process, including:

- a. An application with instructions for submitting an IMR request, including the DMHC's toll-free telephone number for further information, and an envelope addressed to the Department of Managed Health Care, HMO Help Center, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.
- b. CalOptima Health shall include on the form any information required by the DMHC to facilitate the completion of the IMR, such as the Member's diagnosis or condition, the nature of the Disputed Health Care Service sought by the Member, a means to identify the Member's case, and any other material information). CalOptima Health will also include a copy of DMHC's physician certification form using the DMHC Physician Certification Experimental/ Investigational Denials (DMHC/IMR 110-11/27/00) and inform the Member that the certification from the Member's treating physician must include the information required by 28 CCR § 1300.70.4(d) for an IMR of experimental and investigational therapies.
- c. A statement informing the Member that participation in CalOptima Health's Grievance system is not required prior to seeking IMR.

h. Translate Resolution Letters into Threshold Languages and offer oral Interpretation for all other languages, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

i. Close the case in the GARS database by documenting the disposition of the Appeal, reviewing entity(ies), decision and any action taken (if any), including a copy of the Resolution Letter in the electronic file, and documenting any oral notification provided to the Member.

3. Expedited Appeal Process

a. If CalOptima Health determines pre-service or contemporaneously with the service, or when the Member or Provider indicates, that taking the time for a standard Resolution could seriously jeopardize the Member's life or health or ability to maintain, or regarding maximum function, the Appeal will be processed as a request for Expedited Appeal. Requests for Expedited Appeal shall be processed as follows:

- i. A CalOptima Health Member, or a Provider or Member's Authorized Representative acting on behalf of the CalOptima Health Member and with the Member's written consent, may request an Expedited Appeal by contacting CalOptima Health's Customer Service Department by telephone or in-person, or contacting CalOptima Health's Grievance and Appeals Resolution Services by facsimile, in writing, or through the CalOptima Health Website at www.caloptima.org.
- ii. CalOptima Health staff shall immediately inform the Member of:
 - a) The limited time to present evidence in person or writing to support the Appeal:

- 1 b) Their right to contact DMHC regarding their Expedited Appeal (verbally and in
2 writing by sending or providing a hard copy of the Enrollee Grievance Process
3 which describes their Urgent Grievance/Expedited Appeal rights); and
4
5 c) That there is no requirement for the Member to participate in the CalOptima Health
6 Grievance process prior to applying to DMHC for review of the Expedited Appeal.
7
8 d) If a Member submits an Urgent Grievance to the DMHC for expedited review,
9 CalOptima Health shall notify the DMHC before changing or modifying any
10 benefit or services that relates to the Urgent Grievance if the Member or their
11 Authorized Representative objects to the change or modification.
12
13 b. Upon receipt of a Member request for an Expedited Appeal, CalOptima Health's CMO or
14 Designee shall review the request to determine if the case involves an imminent and serious
15 threat to the health of the patient, including, but not limited to, severe pain, potential loss of
16 life, limb, or major bodily function.
17
18 c. CalOptima Health shall grant Expedited Appeal requests if the Appeal is:
19
20 i. Related to admission, continued stay, or other health care services for a Member who
21 has received Emergency Services but has not been discharged from a facility.
22
23 d. Filed by a physician without further review.
24
25 e. CalOptima Health shall utilize specialist consultants, as appropriate.
26
27 f. CalOptima Health process Expedited Appeals and issue the decision within three (3) days
28 of receipt. CalOptima Health shall provide oral notice of the Resolution of an Expedited
29 Appeal and provide the Member and DMHC with a written statement on the disposition or
30 Pending status of the Expedited Appeal within three (3) days of receiving it.
31
32 g. CalOptima Health shall notify a Member, or a Provider or Authorized Representative acting
33 on behalf of the Member and with the Member's written consent, within twenty-four (24)
34 hours, by telephone, and written notice within three (3) days of the oral notice if the Appeal
35 does not meet Expedited Appeal criteria.
36
37 h. If the Appeal does not meet the criteria for expedited review, CalOptima Health shall notify
38 the Member and DMHC that the Member's case will be processed as a standard Appeal and
39 the Member's right to notify DMHC of the expedited review request.
40
41 i. Expedited Appeals do not require Acknowledgement Letters as the Resolution letter is
42 mailed within three (3) days of receipt date and time.
43
44 j. The Appeal Resolution letter shall contain the same information required for standard
45 Grievances in accordance with CalOptima Health Policy CC.1201: Member Grievance.
46
47 k. If CalOptima Health denies the request for an Expedited Appeal, then GARS staff shall
48 notify the Member as follows:
49
50 i. Verbal Notification: Notify the appealing party and all involved parties of the decision,
51 verbally, no later than one (1) business day of such decision; and
52

- 1 ii. Written Notification: Notify the Member of the decision, in writing, no later than two
2 (2) days of the verbal notice and include:
3
4 a) The reason for the denial; and
5
6 b) The Member's right to file a Grievance, in accordance with CalOptima Health
7 Policy CC.1201: Member Grievance, if they disagree with CalOptima Health's
8 denial decision.
9

10 4. Pre-service Appeals Resolution (Standard and Expedited)
11

- 12 a. Except as otherwise provided in Section III.C.3. of this policy, CalOptima Health shall send
13 to the Member and Provider, as appropriate, an Appeal Resolution Letter within thirty (30)
14 days after receipt of the Appeal.
15
16 b. If CalOptima Health completely overturns the denial, the letter shall state the decision and
17 the date of the decision. CalOptima Health shall also ensure the written response contains a
18 clear and concise explanation of the reason, including the reason for why the decision was
19 overturned.
20
21 c. If CalOptima Health does not completely overturn the denial, the Appeal Resolution Letter
22 shall include information including: the title, qualification and specialty of the person
23 making the decision, how the Member or Provider may obtain copies of the Appeal file
24 documentation or criteria used to make the Appeal decision, the Member's right to request a
25 standard or expedited IMR.
26
27 d. If CalOptima Health upholds a decision involving the delay, denial, or modification of
28 health care services, the Appeal Resolution Letter shall include information regarding the
29 title, qualification, and specialty of the person making the decision and the specific reasons
30 for the Appeal decision, in easy-to-understand language, and a reference to the specific
31 criteria, guideline or protocol used, and clinical reasons for the decision as it applies to the
32 Member.
33
34 e. If CalOptima Health upholds an Appeal decision for health care services based in whole or
35 in part on findings that the services are not Covered Services, the Appeal Resolution Letter
36 shall include information regarding the title of the person making the decision and clearly
37 specify the provisions of the contract that exclude that service, Evidence of Coverage or the
38 Member handbook reference for excluded services. The response shall either identify the
39 document and page where the provision is found, direct the Member to the applicable
40 section of the contract containing the provision, or provide a copy of the provision and
41 explain in clear concise language how the exclusion applied to the specific health care
42 service or benefit requested by the enrollee. The response shall also include a notice that if
43 the Member believes the decision was denied on the grounds that it was not Medically
44 Necessary, the Member may contact the DMHC to determine whether the decision is
45 eligible for IMR.
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47 f. CalOptima Health and a Health Network shall take immediate action to implement the
48 decision as expeditiously as the Member's condition requires and in accordance with the
49 timeframes as required in CalOptima Health Policy GG.1507: Notification Requirements
50 for Services Requiring Prior Authorization.
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52 D. Post-service Appeal Processing
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1. CalOptima Health GARS staff shall obtain all documentation related to the Appeal, including but not limited to any claims submitted on behalf of the Member, Provider information, Member's referral and authorization history, and clinical history documentation on file, as well as any information provided by the Member, Authorized Representative, or Provider.
2. A GARS Appeals nurse shall investigate, review, and summarize the Appeal history and documentation, including any aspects of clinical care involved, for submission to CMO or their Designee for review.
3. All medical Appeals are referred to the CMO or their Designee who has the authority to require corrective action, is of the same or similar specialty, is able to treat complications that may result from the service or procedure and did not make the initial utilization management decision.
4. CalOptima Health shall utilize specialist consultants as appropriate.
5. Post-service Appeals Resolution
 - a. CalOptima Health shall send to the Member and Provider, as appropriate, an Appeal Resolution Letter within thirty (30) days after receipt of the Appeal.
 - b. If CalOptima Health completely overturns the decision, the Appeal Resolution Letter shall state the decision and the date of the decision. CalOptima Health shall also ensure the written response sent to the appealing party contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.
 - c. If CalOptima Health does not completely overturn the decision, the Appeal Resolution Letter shall include information regarding the name and title of the person making the decision, how the Member or Provider may obtain, upon request, copies of the Appeal file documentation or criteria used to make the Appeal decision; the Member's right to request a standard or expedited IMR.
 - d. If CalOptima Health upholds an Appeal decision, in whole or in part, the Appeal Resolution Letter shall describe the specific reasons for the Appeal decision in easy-to-understand language, a reference to the specific criteria, guideline or protocol used and clinical reasons for the decision as it applies to the Member.
 - e. CalOptima Health and a Health Network shall take immediate action to implement the decision as expeditiously as the Member's condition requires and in accordance with the timeframes as required in CalOptima Health Policy GG.1507: Notification Requirements for Services Requiring Prior Authorization.

E. Independent Medical Review

1. A Member may apply to the DMHC for an IMR when all of the following conditions are met:
 - a. One of:
 - i. The Member's Provider has recommended a health care service as Medically Necessary;
 - ii. The Member has received Urgent Care or Emergency Services that a Provider determined were Medically Necessary; or

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iii. The Member has been seen by a contracted Provider for the diagnosis or treatment of the medical condition for which the Member seeks independent review. CalOptima Health shall expedite access to a contracting Provider upon request of a Member. The contracting Provider need not recommend the Disputed Health Care Service as a condition for the Member to be eligible for IMR. For purposes of the IMR, the Member's Provider may be a noncontracted Provider; however, CalOptima Health shall have no liability for payment of services provided by a noncontracted Provider, except as provided in accordance with Section III.E.6. of this policy.

- b. The Disputed Health Care Service has been denied, modified, or delayed by CalOptima Health or a Health Network, or by one (1) of its contracted providers, based in whole or in part on a decision that the health care service is not Medically Necessary.
- c. The Member has filed an Appeal/Grievance with CalOptima Health or a contracted Provider and the Appeal is upheld or remains unresolved after thirty (30) days. For Expedited Appeals or any other cases where the DMHC determines that extraordinary and compelling circumstances exist, which include, but are not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate, and serious deterioration of the health of the Member, the Member shall not be required to participate in the Appeal process for more than three (3) days.
- d. Any case in which a Member or Provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of Medical Necessity, the DMHC shall have the final authority to determine whether the Grievance/Appeal is more properly resolved pursuant to an IMR or DMHC review of a Grievance. The DMHC shall also have final authority to determine whether a Grievance is a Disputed Health Care Service or a Coverage Decision.

2. A Member may apply to the DMHC for an IMR of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the Disputed Health Care Services are not Medically Necessary, within six (6) months of any of the qualifying periods or events described above, or in cases where the DMHC has determined the circumstances warrant a longer application deadline.

3. If CalOptima Health is notified by DMHC that a that an application for IMR has been assigned to an IMR organization, CalOptima Health shall provide the organization with all information that was considered in relation to the Disputed Health Care Service, the Member's Grievance, and CalOptima Health's determination. Unless otherwise advised in the notification or by the assigned review organization, CalOptima Health shall submit a complete set of the materials listed below to the IMR organization within three (3) business days for standard Appeals, or within twenty-four (24) hours for Expedited Appeals:

- a. A copy of all correspondence from and received by CalOptima Health concerning the Disputed Health Care Service, including any Member Grievance related to the requested service;
- b. A complete and legible copy of all Medical Records and other information used by CalOptima Health and its Health Networks in making the decision regarding the Disputed Health Care Service. An additional copy of medical records shall be submitted for each reviewer. Copies of Medical Records relevant to the following will be provided:
- i. The Member's medical condition;

- 1 ii. The services currently provided by CalOptima Health and its Health Networks for the
2 Member's condition; and
3 iii. The Disputed Health Care Service requested by the Member for the condition.
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5 c. A copy of the cover page of the EOC and complete pages with the referenced sections
6 highlighted or underlined sections, if the EOC was reference in CalOptima Health's
7 Resolution;
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9 d. CalOptima Health's response to any additional issues raised in the Member's application
10 for IMR.
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12 e. CalOptima Health shall promptly provide the Member with an annotated list of all
13 documents submitted to the independent review organization, together with information on
14 how copies may be requested.
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16 f. Any newly developed or discovered relevant Medical Records in possession of CalOptima
17 Health shall be immediately forwarded to the IMR organization and the Member or the
18 Member's Provider, if authorized by the Member, unless the offer of Medical Records is
19 declined or otherwise prohibited by law.
20
21 g. Copies of all information CalOptima Health provided to the Member and Providers and
22 Member provided to CalOptima Health concerning the plan and Provider decisions
23 regarding the Member's condition, care, or support of the Disputed Health Care Service,
24 including copies of CalOptima Health's Appeal Resolution Letter.
25
26 h. Copies of any other relevant documents or information used by CalOptima Health or its
27 Providers in determining whether the Disputed Health Care Service should be provided, and
28 any statements explaining the reasons for the decision to deny, modify, or delay Disputed
29 Health Care Services on the basis of medical necessity.
30
31 4. The confidentiality of all Medical Record information and medical information provided
32 outside of the Medical Record shall be maintained pursuant to applicable state and federal laws.
33
34 5. CalOptima Health shall also provide additional information as follows:
35
36 2. Any Medical Records or other relevant matters not available at the time of the DMHC's
37 initial notification, or that result from the Member's ongoing medical care or treatment for
38 the medical condition or disease under review. Such matters shall be forwarded as soon as
39 possible upon receipt by CalOptima Health, not to exceed five (5) business days in routine
40 cases or one (1) calendar day in expedited cases.
41
42 3. Additional Medical Records or other information requested by the IMR organization shall
43 be sent within five (5) business days in routine cases or one (1) calendar day in expedited
44 cases. In expedited reviews, CalOptima Health shall immediately notify the Member and
45 the Member's Provider by telephone or facsimile to identify and request the necessary
46 information, followed by written notification, when the request involves materials not in
47 CalOptima Health's or its contracting Providers' possession.
48
49 6. Upon notification that DMHC, through the IMR process, has ruled a Disputed Health Care
50 Service as Medically Necessary, CalOptima Health will immediately contact the Member and
51 arrange to authorize the services as expeditiously as the Member's health condition requires.
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- 1 a. In the case of reimbursement for services already rendered, CalOptima Health shall
2 reimburse the Provider or Member, whichever applies, within five (5) business days.
3
4 b. In the case of services not yet rendered, CalOptima Health shall authorize the services
5 within five (5) business days of receipt of the written decision from the DMHC, or sooner if
6 appropriate for the nature of the Member's medical condition and shall inform the Member
7 and Provider of the authorization in accordance with CalOptima Health Policy GG.1507:
8 Notification Requirements for Covered Services Requiring Prior Authorization.
9
10 c. In the case of an external exception request for pharmacy related Appeals that is deemed by
11 the DMHC to be Medically Necessary, CalOptima Health will facilitate authorization as
12 expeditiously as the Member's health condition requires, not to exceed seventy-two (72)
13 hours.
14
15 d. CalOptima Health shall promptly reimburse the Member for any reasonable costs associated
16 with services where:
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18 i. The DMHC finds that the Disputed Health Care Services were a covered benefit under
19 the terms and conditions of the CalOptima Health plan contract;
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21 ii. The services are found by the IMR organization to have been Medically Necessary; and
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23 iii. Either the Member's decision to secure the services outside of the CalOptima Health
24 provider network was reasonable under the Emergency or Urgent medical
25 circumstances, or the CalOptima Health plan contract does not require or provide prior
26 authorization for those health care services.
27
28 G. In any DMHC review of a Grievance involving a Disputed Health Care Service that is not
29 eligible for IMR in which the DMHC finds that CalOptima Health has delayed, denied, or
30 modified health care services that are Medically Necessary, based on the specific medical
31 circumstances of the Member, and those services are a covered benefit under the terms and
32 conditions of the CalOptima Health plan contract, CalOptima Health shall comply with
33 DMHC's binding order and written notice to:
34
35 1. Promptly offer and provide health care services to the Member; or
36
37 2. Promptly reimburse the Member for any reasonable costs associated with Urgent Care or
38 Emergency Services, or other extraordinary and compelling health care services, when the
39 DMHC finds that the Member's decision to secure those services outside of the plan
40 network was reasonable under the circumstances.
41
42 H. Notices, Records, and Reports
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44 1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing,
45 of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted,
46 related procedures regarding the Grievance Process, information regarding DMHC review
47 process, the IMR system, and the DMHC's toll-free telephone number and website address.
48 CalOptima Health shall provide these notices in Threshold Languages, as required by DMHC
49 and Covered California.
50
51 2. CalOptima Health shall keep in its files written records of each Appeal, including copies of
52 Appeal records of any sub-contracting entity delegated the responsibility to maintain and
53 resolve Appeals. The records shall include all Medical Records, documents, evidence of

coverage and other relevant information upon which the plan relied in reaching its decision, the date and time of receipt, Member's name, description of the complaint or problem, names of the CalOptima Health staff who received the Appeal and who is designated as the contact person, description of the action taken to investigate/resolve the problem, Resolution proposed by GARS or the medical professional responsible for making utilization management decision, the name of the CalOptima Health Provider or staff responsible for resolving the Appeal, the date of notification to the Member of Resolution, and all Appeal Resolution letters. CalOptima Health shall maintain the written records, for a minimum of ten (10) years.

3. CalOptima Health shall continually evaluate and analyze Appeal data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.
4. CalOptima Health shall submit, on a quarterly basis, aggregated and detailed Appeals data to the Quality Assurance Committee.
5. CalOptima Health shall establish and maintain a system of aging of Appeals that are Pending and unresolved for thirty (30) days or more. The system shall also track and monitor Appeals received and resolved, including the number received and resolved, whether each Appeal was resolved in favor of the member or CalOptima Health, the number pending more than thirty (30) days, the applicable product category, and the status and location of pending Appeals.
6. Aging Grievances Report. CalOptima Health's Grievance system shall track and document aging Grievances, which are Grievances that are Pending and unresolved for thirty (30) days or more and shall include Appeals. The Grievance system shall also categorize tracked Grievances and Appeals by type, including, as applicable, coverage disputes, Medical Necessity disputes, quality of care, access to care, quality of service, and other issues. CalOptima Health shall provide a quarterly report to DMHC of Grievances Pending and unresolved for thirty (30) or more days. The report shall be verified by CalOptima Health's Director of Grievance and Appeals Resolution Services and submitted as specified in Section G of CalOptima Health Policy CC.1201: Member Grievance, Title 28, California Code of Regulations § 1300.68(i), and Department of Managed Health Care All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8, 2022).
7. The written record of Appeals shall be reviewed periodically by CalOptima Health's Governing Board, the Member Advisory Committee, and Provider Advisory Committee and the Chief Operating Officer or Designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.
 - a. GARS shall present to the Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Health and Safety Code §§ 1365, 1367.01(e),(h)(3), and (j),1368 (a)(1), (a)(4)(B), 1368.01(a)-(b), 1368.016, 1368.02(b), 1367.24, 1368.015, 1370.2, 1371.34, 1374.30 (e), (i), (j)(1) and (3) (l), (m), (n), 1374.31, 1374.34(a).
- B. CalOptima Health Appeal Acknowledgement Letter
- C. CalOptima Health Appeal Resolution Letter – Overturn
- D. CalOptima Health Appeal Resolution Letter – Uphold
- E. CalOptima Health Expedited Appeal Acknowledgement (Downgrade) Letter
- F. CalOptima Health Contract with Covered California
- G. CalOptima Health Language Assistance Taglines
- H. CalOptima Health Member Complaint Form
- I. CalOptima Health Member Grievance Process
- J. CalOptima Health Member Non-discrimination Notice
- K. CalOptima Health Policy CC.1201: Member Grievance
- L. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint
- M. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
- N. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
- O. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
- P. CalOptima Health Policy HH.1104: Discrimination and TGI-Related Grievances
- Q. CalOptima Health Policy HH.1109: Complaint Decision Matrix
- R. Department of Managed Health Care All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8, 2022)
- S. Standards and Guidelines for the Accreditation of Health Plans
- T. Title 28, California Code of Regulations (C.C.R.), §§ 1300.68(a), (a), (b)(3)-(b)(8), 1300.85, 1300.85.01
- U. Title 45, Code of Federal Regulations (C.F.R.), § 156.122(c)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1200	Member Appeal Process	Covered California

IX. GLOSSARY

Term	Definitions
Appeal	A type of Grievance related to any of the following Medical Necessity determination or coverage actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability.
Appeal Acknowledgement/Resolution Letter	A written statement acknowledging receipt of, or resolving, an Appeal.
Appeal Process	The process by which CalOptima Health and its Health Networks address and provide Resolution to all Appeals.
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 DHCS State Fair Hearings, 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.
Coverage Decision	Covered California: The approval or denial of health care services by CalOptima Health or a Health Network substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Member's CalOptima plan contract. A "coverage decision" does not encompass a CalOptima Health or Health Network decision regarding a disputed health care service.
Covered Service	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.

Term	Definitions
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations and other managed care plans.
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.
Disputed Health Care Service	Any health care service eligible for coverage and payment under a CalOptima Health plan contract that has been denied, modified, or delayed by a decision of CalOptima Health, or by one of its contracting Providers, in whole or in part due to a finding that the service is not Medically Necessary. A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a coverage decision.
Emergency Services	Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in and Health & Safety Code § 1317.1(a)(1) and §1317(a)(2)(A).
Expedited Appeal	A type of Urgent Grievance involving an Appeal.
Governing Board	CalOptima Health's Board of Directors or a similar body, and/or its executive management, that has the authority to manage and direct CalOptima Health's affairs and activities, including, but not limited to, approving initiatives and establishing CalOptima Health's policies and procedures.
Grievance/Grievant	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. A Grievant is the individual making or filing the Grievance.
Grievance Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.
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.
Independent Medical Review (IMR)	A review of CalOptima Health's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on CalOptima Health pursuant to Health and Safety Code § 1374.30 and Title 28 California Code of Regulations §1300.74.30.
Interpret/Interpretation	The act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).

Term	Definitions
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.
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).
Member	An individual enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Pending	Grievances or Appeals that are not resolved within thirty (30) days, or that are referred to the DMHC's complaint or independent medical review system or other external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, as applicable.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
Relative	A parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the Member.
Resolved/Resolution	The Grievance has reached a final conclusion with respect to the Member's submitted Grievance and there are no Pending Member appeals within CalOptima Health's Grievance system, including any entities with delegated authority.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.

Term	Definitions
Urgent Care	Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the plan's service area.
Urgent Grievance	Grievances that involve an imminent and serious threat to the mental or physical health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

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For 20261001 BOD Review Only



Policy: CC.1201
Title: **Member Grievance**
Department: Grievance and Appeals Resolution Services
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2027
Revised Date: Not Applicable

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

I. PURPOSE

This policy defines the process by which CalOptima ~~Health~~ Health's Grievance system addresses and resolves Grievances from a Member, or a Provider or Authorized Representative acting on behalf of a Member with the Member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima Health shall establish and maintain a Grievance system pursuant to applicable federal and state laws and regulations, including the Knox-Keene Act and its implementing regulations. CalOptima Health's Grievance system is composed of the Grievance Process outlined in this policy and the Appeal Process outlined in CalOptima Health Policy CC.1200: Member Appeal Process. The Appeal Process applies to standard and expedited pre-service and post-service Appeals, which are a subset of Grievances that involve medical necessity determinations and coverage decisions. The Grievance Process outlines CalOptima Health's process for resolving Grievances that do not involve Medical Necessity determination or coverage decisions. Both the Appeal and Grievance Processes receive and resolve "Grievances", as that term is used under the Knox-Keene Act in accordance with the requirements therein.

~~A.B.~~ CalOptima Health shall establish and maintain a Grievance Process pursuant to which a Member, or a Provider or Authorized Representative acting on behalf of a Member with the Member's written consent, may submit a Grievance for review and Resolution either orally or in writing.

~~B.C.~~ CalOptima Health's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.

~~C.D.~~ A Member need not use the term "Grievance" for a Complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the Complaint shall still be categorized as a Grievance.

~~D.E.~~ Members have the right to submit a Grievance against named individual(s), subcontractors, downstream subcontractors, or staff for failure to provide Trans-Inclusive Health Care. If a Grievance Resolution on Trans-Inclusive Health Care is decided in the Member's favor, the Grievance and Appeals Resolution Services (GARS) specialist will notify the Human Resources (HR) or Provider Relations (PR) departments for those individuals that must retake the Trans-Inclusive Health Care cultural competency training.

1. Upon notification from GARS, HR (for employee-related Grievances) and/or PR (for Provider, vendor, and subcontractor related Grievances) will conduct and track re-training as follows:
 - a. The Transgender, Gender Diverse, Intersex (TGI) cultural competency re-training will be conducted within forty-five (45) calendar days of the notification and before the individual requiring re-training has direct contact with Members again.

~~E.F.~~ CalOptima Health shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency, disabilities, or cultural needs.

~~F.G.~~ CalOptima Health shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance.

~~G.H.~~ CalOptima Health shall process expedited requests timely in instances where a Provider indicates, or CalOptima Health determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function: (Urgent Grievance).

~~H.I.~~ CalOptima Health shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and they are not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease in accordance with CalOptima Health Policy CC.1200: Member Appeal Process.

~~I.J.~~ CalOptima Health shall refer all potential medical quality-of-care issues identified through the Grievance Process to the Quality Improvement (QI) Department for review.

~~J.K.~~ CalOptima Health shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that the individual filed a Grievance, as required by federal and state nondiscrimination law and in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination and TGI-Related Grievances.

~~K.L.~~ CalOptima Health shall inform a Member of their right to file a Grievance through CalOptima Health for at least one hundred eighty (180) calendar days following any incident to express dissatisfaction about any matter ~~other than an action resulting in a Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA)~~. Grievances shall be handled in accordance with the provisions of this CalOptima Health Policy CC.1200 Member Appeal Process.

1. A Member's Provider or Authorized Representative, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance within the one hundred eighty (180) day timeframe specified above.

1 L.M. CalOptima Health shall inform a Member, during the Grievance Process, of their right to
2 request ~~an Independent Medical Review (IMR) or file a Complaint with~~ review by the
3 Department of Managed Health Care (DMHC) after participating in the Grievance ~~process in~~
4 ~~accordance with~~ Process for thirty (30) days. CalOptima Health ~~Policy CC.1200: shall inform a~~
5 Member ~~Appeal Process.~~ that they may contact the DMHC at any time to request a review and do
6 not have to participate in the Grievance Process for thirty (30) days if the Grievance:
7

8 1. If a Member has filed a Grievance with CalOptima Health and the disputed
9 decision is upheld or the Grievance remains unresolved after thirty (30) calendar
10 days, the Member shall not be required to participate in CalOptima Health's
11 Grievance Process for more than thirty (30) calendar days. In the case of a
12 Grievance that requires expedited review, the Member shall not be required to
13 participate in CalOptima Health's Grievance Process. Is an Urgent Grievance;
14

15 2. Relates to cancellations, rescissions, or the nonrenewal of the Member's CalOptima contract; or
16

17 3. Has been determined by the DMHC that an earlier review is warranted.
18

19 L.M. For grievances involving delay, modification, or denial of services based on a determination in
20 whole or in part that the service is not Medically Necessary, CalOptima Health shall inform a
21 Member of their right to request an Independent Medical Review (IMR) in accordance with
22 CalOptima Health Policy CC.1200: Member Appeal Process.
23

24 M.N. CalOptima Health shall give a Member a reasonable opportunity to present, in writing or in
25 person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in
26 support of the Grievance. CalOptima Health or a Health Network shall inform the Member of the
27 limited time available to present evidence sufficiently in advance of the Resolution timeframes,
28 including for Urgent Grievances.
29

30 N.O. CalOptima Health shall consider all comments, documents, records, and other information
31 submitted by the Member, or the Member's Authorized Representative or Provider, regardless of
32 whether such information was submitted or considered during the initial review.
33

34 O.P. CalOptima Health shall provide the opportunity, before and during the Grievance Process, to
35 examine and or obtain a copy of the Member's case file, including the Medical Record, and any
36 other relevant documents and records considered during the Grievance Process, upon request by the
37 Member, or a Provider or Authorized Representative acting on behalf of the Member and with the
38 Member's written consent. CalOptima Health shall provide records at no cost.
39

40 P.O. CalOptima Health and its Health Networks shall provide culturally and linguistically
41 appropriate notices of the Grievance Process to Members, including language assistance taglines
42 and a notice of non-discrimination in compliance with the requirements set forth by the DMHC, and
43 in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
44

45 Q.R. A Member, or a Provider or Authorized Representative acting on behalf of the Member with the
46 Member's written consent, may submit a request to Appeal a decision not related to a utilization
47 management decision with any supporting documentation to GARS. Such request shall be
48 considered a Non-Coverage Appeal, and CalOptima Health shall process the request as a Grievance
49 and in accordance with Section III.E. of this policy.
50

1 S. CalOptima Health shall be available twenty-four (24) hours a day, seven (7) days a
2 week to receive communications from the DMHC regarding Urgent Grievances.

3
4 R.1. During normal work hours, CalOptima Health shall respond to the DMHC
5 within thirty (30) minutes after initial contact and within one (1) hour during non-
6 work hours.

7
8 +2. CalOptima Health has designated plan representatives, including back-up plan
9 representatives as necessary, who have the authority to resolve Urgent Grievances and
10 authorize the provision of health care services in a medically appropriate and timely manner.
11 Such authority includes making financial decisions for expenditure of funds on behalf of
12 CalOptima Health without first having to obtain approval from supervisors or other superiors;
13 however, the plan representative may consult with other plan staff on Urgent Grievances.

14
15 3. If CalOptima Health revises the staffing plan for DMHC to be able to contact a plan
16 representative regarding Urgent Grievances, it shall notify the DMHC at least thirty (30) days in
17 advance of implementing the revisions.

18
19 S.T. Responsible ~~staff~~ Staff

- 20
21 1. CalOptima Health's Chief Operating Officer shall have primary responsibility for:
22
23 a. Maintenance of the Grievance Process;
24
25 b. Review of the operations; and
26
27 c. Identification of any emerging or systemic issues of Grievances and Appeals and/or patterns
28 of improper service denials in the formulation of policy changes and procedural
29 improvements to CalOptima Health's administration of the program.
30
31 2. CalOptima Health's Director of GARS shall have primary responsibility for the oversight of the
32 Grievance Process.

33
34 U. CalOptima Health shall maintain a Grievance system/platform that has the ability to:

- 35
36 1. Monitor the number of Grievances received and resolved, including whether the Grievance was
37 resolved in favor of the Member of CalOptima Health, and the number of Grievances pending
38 over thirty (30) calendar days.
39
40 2. Track grievances under categories of:
41
42 a. Commercial
43
44 b. Medicare
45
46 c. Medi-Cal/other contracts
47
48 3. Indicate whether a Member Grievance is pending at:
49

a. CalOptima's internal Grievance system;

b. DMHC's consumer complaint (review) process;

c. DMHC's IMR process;

d. An action filed or before a trial or appellate court; or

e. Other dispute resolution process.

4. Additionally, the system shall indicate whether a Grievance has been submitted to arbitration.

5. Indicate the total number of Grievances received, pending and resolved in favor of the Member at all levels of Grievance review and to describe the issue or issues raised in Grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care, (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

2.

III. PROCEDURE

A. Unless otherwise specified, CalOptima Health shall resolve all possible levels of internal Grievances or Appeals within thirty (30) calendar days of the receipt of the Grievance.

B. Assistance to Members

1. CalOptima Health shall make Complaint forms and procedures for filing a Grievance available at each facility that provides Covered Services to Members, on CalOptima Health's website, and from each contracting Provider's office or facility.
2. CalOptima Health shall promptly provide Complaint forms and procedures to a Member upon request.
3. CalOptima Health's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances and shall triage Member calls and route Grievances to the GARS Department via its electronic system.
4. CalOptima Health shall ensure that Members accessing the Grievance system are given assistance in completing Grievance forms and other procedural steps, including but not limited to providing auxiliary aids and services upon request, such as ~~interpreter~~Interpreter services and a toll-free number with TTY/TDD and ~~interpreter~~Interpreter capability in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

C. Exempt Grievances

1. Grievances received ~~over the by~~ telephone, that are not coverage disputes, Disputed Health Care Services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt

Grievance.

2. CalOptima Health Customer Service and GARS Departments shall maintain records and logs of Standard, Urgent, and Exempt Grievances, including the date of receipt, name of ~~complainant~~Complainant, Member's name and Member identification number, nature of the Grievance, name(s) of the CalOptima Health staff who received the Grievance, and name of the CalOptima Health staff who Resolved the Grievance.
3. CalOptima Health Customer Service Department shall, on a monthly basis, provide an Exempt Grievance and "Declined Grievance" report to GARS to be aggregated for tracking and trending purposes as with other Grievances.
4. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to the CalOptima Health Customer Service Department by telephone, or in person.
5. The CalOptima Health Customer Service Department staff shall:
 - a. Identify and document the nature of the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;
 - b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of the Member; and
 - c. If the Grievance is ~~resolved~~Resolved by the close of the next business day, it shall be classified as an Exempt Grievance.
6. If CalOptima Health Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or Provider acting on behalf of a Member regarding the dissatisfaction, or discontent by close of the next business day, the CalOptima Health Customer Service staff shall:
 - a. Educate the Member, Member's Authorized Representative, or Provider acting on behalf of a Member of Grievance rights in accordance with this Policy and inform them that the issue(s) will be referred to the CalOptima Health GARS Department;
 - b. Inform the Member, Member's Authorized Representative, or Provider acting on behalf of a Member of the Resolution timeframes; and
 - c. If the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to the Grievance referral, route the Grievance to the GARS Department.
7. If the Member, Member's Authorized Representative, or Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service Department staff shall:
 - a. Categorize the issue as a Grievance;

- b. Forward potential quality of care declined Grievances to the CalOptima Health QI Department for review;
- c. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully ~~resolved~~Resolved; and
- d. Close the Grievance with the "Declined Grievance" disposition code.

D. Grievance Process

1. A Member, or Provider or Authorized Representative acting on behalf of the Member, may file a Grievance:
 - a. With CalOptima Health's Customer Service Department, by telephone, or in person; or
 - b. With CalOptima Health GARS, by facsimile, in writing, or through the CalOptima Health website at www.CalOptima.org.
2. GARS shall ensure that Members, or a Member's Provider or Authorized Representative, have equal access to, and can fully participate in, the Grievance process by providing assistance to Members, or a Member's Provider or Authorized Representative, with disabilities, limited English proficiency, vision disorders, or other communicative impairments by providing the following services in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- 2.3. CalOptima Health shall provide language assistance for Threshold Languages and language line interpretation services, as needed, to register and resolve Grievances in all other languages. CalOptima Health shall also translate Grievance correspondence into Threshold Languages and offer oral Interpretation for Grievance correspondence for all other languages in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- 3.4. In the event an oral Grievance is received, CalOptima Health will process the Grievance regardless of whether a signed, written Grievance is subsequently received from the Member.
- 4.5. CalOptima Health shall process a Grievance for discrimination as required by applicable federal and state nondiscrimination laws and in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination and TGI-Related Grievances.
- 5.6. Upon receipt of a Grievance, GARS shall:
 - a. Date stamp and document the substance of the Grievance, and any action taken, including but not limited to the Member's previous Complaint history and follow-up activities associated with the Complaint, in the GARS database, verifying demographics and network affiliation.
 - b. Determine the category of Grievance, including but not limited to ~~the following categories: quality of care, quality of service, access to care, and other, based on the Grievance. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s):~~
 - i. quality of care;

1
2 ii. quality of service;

3
4 iii. access to care;

5
6 iv. and other, based on the Grievance.

7
8 a-c. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).d.

9 Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a
10 Grievance, indicating receipt of the Grievance, the date of receipt of the Grievance, and
11 providing the name, telephone number and address of the GARS staff member whom the
12 Member may contact regarding the Grievance, and provide the Member with an estimated
13 completion date of Resolution. The Acknowledgment Letter shall also include information
14 regarding a Member's right to participate in the Grievance process, as described in this
15 policy.

16
17 b.d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima Health
18 department or Health Network responsible for the services or operations that are the subject
19 of the Grievance.

20
21 e.e. CalOptima Health shall take into consideration the Member's medical condition when
22 determining the response time, particularly for Urgent Grievances, as described in this
23 policy.

24
25 d.f. Refer all Grievances related to potential medical quality of care issues to the QI Department
26 for immediate review by CalOptima Health's Chief Medical Officer (CMO) or their
27 Designee and any action deemed necessary under the quality review process in accordance
28 with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

29
30 e.g. Review and immediately process all Grievances that may seriously jeopardize the
31 Member's life or health or ability to attain, maintain or regain maximum function; (Urgent
32 Grievance), on an expedited basis and issue the decision within seventy-two (72)
33 hours~~three (3) calendar days~~ of receipt. ~~CalOptima Health shall provide oral notice~~
34 ~~of the Resolution of an Urgent Grievance to the DMHC. The procedures for an~~For
35 Urgent Grievance~~Grievances, GARS shall include:~~

36
37 i. ~~Immediate notification to~~Immediately notify the Member or their Authorized
38 Representative of the shortened timeframe to submit information related to their case;
39 ~~and of their right to notify the DMHC of their Grievance. the right to contact the~~
40 ~~DMHC regarding the Urgent Grievance, and that there is no requirement to participate~~
41 ~~in CalOptima Health's grievance process before applying to the DMHC for review of~~
42 ~~the Urgent Grievance. Notification shall be made verbally and in writing by sending or~~
43 ~~providing the Member with a hard copy of the Member Grievance Process, which~~
44 ~~includes these Urgent Grievance rights.~~

45
46
47 ii. ~~If a Member submits an Urgent Grievance to the DMHC for expedited review,~~
48 ~~CalOptima Health shall notify the DMHC before changing or modifying any benefit or~~

1 services that relates to the Urgent Grievance if the Member or their Authorized
2 Representative objects to the change or modification.

3
4 iii. Take into consideration the Member's medical condition when determining the
5 response time.

6
7 iv. Provide a written statement to the DMHC and the Member on the disposition or
8 Pending status of the Urgent Grievance within three (3) calendar days of receipt of the
9 Grievance by CalOptima Health.

10
11 7. Processing of Grievances by Type:

12
13 a. For Grievances involving contested claims, GARS shall refer the claim for review to a
14 licensed and competent health care professional to evaluate the clinical issues of the
15 appealed claim, as applicable.

16
17 b. Grievances for Pharmacy Services: A Member or the Member's Designee or guardian may
18 Appeal a denial of an exception request for coverage of a nonformulary drug, prior
19 authorization request, or step therapy exception request by filing a Grievance in accordance
20 with this policy pursuant to Health and Safety Code § 1367.24 and in compliance with (c)
21 of § 156.122 of Title 45 of the Code of Federal Regulations.

22
23 c. Grievances Related to Privacy Rights: CalOptima Health shall inform a Member of their
24 right to file a Grievance with CalOptima Health or with the Secretary of Health and Human
25 Services regarding violations of their privacy rights, in accordance with CalOptima Health
26 Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of
27 Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

28
29 d. For Grievances involving the cancellation, rescission, or nonrenewal of a CalOptima Health
30 plan contract, CalOptima Health shall continue to provide coverage to the Member under
31 the terms of the CalOptima Health plan contract until a final determination of the Member's
32 request for review has been made by CalOptima Health, or the DMHC pursuant to Health
33 and Safety Code § 1365. This paragraph shall not apply if CalOptima Health cancels or fails
34 to renew the Member's health plan contract for nonpayment of premiums.

35
36 f. Send Upon resolution of a Standard Grievance, GARS shall send the Member, or Provider
37 or Authorized Representative acting on behalf of the Member and with the Member's
38 written consent, a Grievance Resolution Letter, not to exceed thirty (30) calendar days from
39 the date CalOptima Health receives the oral or written Grievance.

40
41 g. Ensure that Members, or a Member's Provider or Authorized Representative,
42 have equal access to, and can fully participate in, the Grievance process by
43 providing assistance to Members, or a Member's Provider or Authorized
44 Representative, with disabilities, limited English proficiency, vision disorders,
45 or other communicative impairments by providing the following services in
46 accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic
47 Services:
48

~~i. Translate Grievance correspondence into Threshold Languages and offer oral interpretation for Grievance correspondence for all other languages.~~

~~2.8.~~ The Grievance Resolution Letter shall describe the Grievance and provide a clear and concise explanation of the reasons for the decision, including but not limited to:

- a. Summary of the Member's Grievance;
- b. The investigation made in the review process, including any referrals to the QI Department for medical quality of care review;
- c. When possible, the outcome of the review; and
- d. Alternative resources or references, when applicable.
- e. If the resolution includes an adverse decision, information regarding the Member's right to Appeal.
- f. For Grievances involving the delay, denial, or modification of services, based on a determination in whole or in part that the service is not medically necessary, the Grievance Resolution Letter shall also describe the following:
 - i. The criteria used and the clinical reasons for CalOptima Health's decision; and
 - ii. The provisions in the Member's CalOptima Health plan contract and/or the Member's Evidence of Coverage that exclude coverage of the specified benefit.

~~3.9.~~ GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, including whether the Grievance was resolved in favor of the Member or CalOptima Health, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

~~4. For Grievances involving contested claims, GARS shall refer the claim for review to a licensed and competent health care professional to evaluate the clinical issues of the appealed claim, as applicable.~~

~~5. Grievances for Pharmacy Services: A Member or the Member's Designee or guardian may Appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a Grievance in accordance with this policy pursuant to Health and Safety Code § 1367.206 and in compliance with (c) of § 156.122 of Title 45 of the Code of Federal Regulations.~~

~~6. a. Grievances Related to Privacy Rights: CalOptima Health shall inform a Member of their right to file a Grievance with CalOptima Health or with the Secretary of Health and Human Services regarding violations of their privacy rights, in accordance with CalOptima Health Policy HHI.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.~~

~~7.a. For Grievances involving the cancellation, rescission, or nonrenewal of a CalOptima Health plan contract, CalOptima Health shall continue to provide coverage to the Member under the terms of the CalOptima Health plan contract until a final determination of the Member's request for review has been made by CalOptima Health, or the DMHC pursuant to Health and Safety Code § 1365. This paragraph shall not apply if CalOptima Health cancels or fails to renew the Member's health plan contract for nonpayment of premiums.~~

E. Non-Coverage Appeals

1. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a request to Appeal a decision not related to a utilization management decision with any supporting documentation to GARS ~~within sixty (60) calendar days of the date of the Non-Coverage Decision Resolution Letter.~~ This type of Grievance is considered a Non-Coverage Appeal and is separate from the Appeal process in CalOptima Health Policy CC.1200: Member Appeal Process.
2. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may file the Non-Coverage Appeal with CalOptima Health's Customer Service Department by telephone or in person, or with GARS via facsimile, in writing or through the CalOptima Health Website at www.CalOptima.org.
3. CalOptima Health shall provide language assistance by CalOptima Health staff for Threshold Languages and language line ~~interpretation~~ Interpretation services, as needed, to register and resolve Grievances in all other languages.
4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.
5. Upon receipt of the Non-Coverage Appeal, GARS shall:
 - a. Date stamp and document the substance of the Non-Coverage Appeal, including the member's reason for appealing the previous decision, and any action taken, into its electronic system, verifying demographics and network affiliation;
 - b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s); and any follow-up activities related to the Non-Coverage Appeal;
 - c. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating the date of receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Non-Coverage Appeal;
 - d. Triage and investigate the Non-Coverage Appeal and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Complaint;
 - e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Health CMO or their Designee and any action deemed necessary under the quality review process;

- 1 f. Review and immediately process all Non-Coverage Appeals involving an imminent and
2 serious threat to the health of a Member including, but not limited to, severe pain or
3 potential loss of life, limb, or major bodily function, on an expedited basis for effectuation
4 of the decision within ~~seventy-two (72) hours~~three (3) calendar days of receipt:
5
6 i. CalOptima Health shall expedite its review of the Urgent Grievance when a Member,
7 an Authorized Representative, or treating physician provides notice to CalOptima
8 Health. Notice need not be in writing but may be accomplished by a documented
9 telephone call.
10
11 g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30)
12 calendar days of the receipt of the Grievance and include the next level ~~Appeal~~appeal
13 rights attachments including the right to file a Complaint with DMHC.
14
15 i. CalOptima Health shall provide language assistance, by CalOptima Health staff for
16 Threshold Languages and language line ~~interpretation~~Interpretation services, as
17 needed to register and resolve Grievances in all other languages.
18
19 ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to
20 requests for access to out-of-network Providers or change of Health Networks, the
21 Grievance Resolution Letter shall include:
22
23 a) Summary of the Member's Non-Coverage Appeal;
24
25 b) Description of actions taken to review the request;
26
27 c) Date and name of position of staff involved in the review; and
28
29 d) Date of the issuance of the decision.
30
31 e) Information regarding the Member's right to further Appeal, as appropriate,
32 including the right to file a Complaint with DMHC.
33
34 6. CalOptima Health shall take immediate action to implement the decision, in accordance with
35 the Grievance Resolution Letter ~~and in accordance with CalOptima Health Policy GG.1507:~~
36 Notification Requirements for Services Requiring Prior Authorization.
37
38 7. GARS staff shall close the case in its electronic system by documenting the disposition of the
39 Non-Coverage Appeal, reviewing entity(ies), decision and any additional action taken (if any),
40 and include a copy of the Grievance Resolution Letter and document any oral notification
41 provided to the Member, and Resolution date.
42

43 F. DMHC Review Process

- 44
45 1. A Member shall not be required to participate in CalOptima Health's Grievance Process:
46
47 a. For more than thirty (30) days for Standard Grievances;
48
49 b. For more than three (3) days, for Urgent Grievances that require expedited review; or,
50
51 c. When the DMHC determines that the case involves an imminent and serious threat to

the health of the Member, including, but not limited to:

- i. severe pain, the potential loss of life, limb, or major bodily function;
- ii. cancellations, rescissions, or the nonrenewal of the health plan contract; or
- iii. in any other case where the DMHC determines that extraordinary and compelling circumstances exist and an earlier review is warranted.

- 2. A Member or Authorized Representative may submit a Grievance to the DMHC for review and resolution prior to any arbitration.
- 3. A Member or Authorized Representative may authorize a Provider to assist the Member in submitting the Grievance to the DMHC and advocating on behalf of the Member.
- 4. In any case in which a Member or Provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the DMHC shall have the final authority to determine whether the Grievance is more properly resolved pursuant to an IMR or DMHC review. The DMHC shall also have final authority to determine whether a Grievance is a Disputed Health Care Service or a Coverage Decision.
- 5. If DMHC determines that a Grievance qualifies for IMR, CalOptima Health shall follow the IMR process outlined in CalOptima Health Policy CC:1200 Member Appeal Process.
- 6. Upon notice from the DMHC that a Member has submitted a Grievance to the DMHC for review, CalOptima shall provide the following information to the DMHC within five (5) calendar days after notification:
 - a. A written response to the issues raised by the Grievance.
 - b. A copy of CalOptima Health's original response sent to the Member regarding the Grievance.
 - c. A complete and legible copy of all medical records related to the Grievance. CalOptima Health shall inform the DMHC if medical records were not used in resolving the Grievance.
 - d. A copy of the cover page and all relevant pages of the Member's Evidence of Coverage (EOC), with the specific applicable sections underlined. If CalOptima Health relied solely on the EOC, it shall notify the DMHC of that fact.
 - e. All other information used by CalOptima Health or relevant to the resolution of the Grievance.
 - f. If the DMHC requests additional information or medical records, CalOptima Health shall forward information and records that are maintained by CalOptima Health or any contracting provider within five (5) calendar days of receipt of the DMHC's request. If requested information cannot be timely forwarded to the DMHC, CalOptima Health's response shall describe the actions being taken to obtain the information or records and when receipt is expected.

1 7. If the DMHC reviews a Grievance involving a Disputed Health Care Service, as defined in
2 Health and Safety Code §1374.30(b), that is not eligible for IMR and finds that CalOptima
3 Health has delayed, denied, or modified health care services that are Medically Necessary,
4 based on the specific medical circumstances of the Member, and those services are a
5 covered benefit under the terms and conditions of the CalOptima Health plan contract,
6 CalOptima Health shall comply with the DMHC's binding order and written notice to:
7

8 a. Promptly offer and provide those health care services to the Member; or,
9

10 b. Promptly reimburse the Member for any reasonable costs associated with Urgent Care
11 or Emergency Services, or other extraordinary and compelling health care services,
12 when the DMHC finds that the Member's decision to secure those services outside of
13 the CalOptima Health network was reasonable under the circumstances.
14

15
16
17 F.G. Notices, Records, and Reports
18

- 19 1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing,
20 of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted,
21 related procedures regarding the Grievance Process, information regarding the DMHC review
22 process, the Independent Medical Review system, and the DMHC's toll-free telephone number
23 and website address. CalOptima Health shall provide these notices in Threshold Languages, as
24 required by the DMHC and Covered California.
25
26 2. CalOptima Health shall keep in its files written records of each Grievance, including copies of
27 Grievance records of any sub-contracting entity delegated the responsibility to maintain and
28 resolve Grievances. The records shall include all Medical Records, documents, evidence of
29 coverage and other relevant information upon which the plan relied in reaching its decision, the
30 date and time of receipt, Member's name, description of the Complaint or problem, names of
31 the CalOptima Health staff who received the Grievance and who is designated as the contact
32 person, description of the action taken to investigate/resolve the problem, Resolution proposed
33 by GARS or the medical professional responsible for making a utilization management
34 decision, the name of the CalOptima Health Provider or staff responsible for resolving the
35 Grievance, the date of notification to the Member of Resolution, and all Grievance Resolution
36 Letters. CalOptima Health shall maintain the written records, for a minimum of ten (10) years.
37
38 3. CalOptima Health shall continually evaluate and analyze Grievance data to identify systemic
39 patterns of improper services denials and other trends impacting health care delivery to
40 Members.
41
42 4. On a quarterly basis, CalOptima Health shall submit all recorded Member Grievances related to
43 access to care, quality of care, and denial of services to the QI Committee to review and take
44 appropriate action to remedy any problems identified in such reviews.
45
46 5. Aging Grievances Report. CalOptima Health's Grievance system shall track and document
47 aging Grievances, which are Grievances that are Pending and unresolved for thirty (30)
48 calendar days or more ~~and shall include a brief explanation of the reasons for~~
49 ~~each Pending and unresolved Grievance.~~ CalOptima Health shall provide a
50 quarterly report to the DMHC of Grievances Pending ~~and unresolved for thirty~~
51 ~~(30) or more calendar days.~~

1
2 5.a. The report shall be verified by CalOptima Health's Director of GARS and submitted as
3 specified in Title 28, California Code of Regulations § 1300.68(i).
4

5 b. CalOptima Health may request the DMHC to include the following statement in the
6 quarterly report that is made public: "Under Medicare and Medi-Cal law, Medicare
7 enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not
8 available to other enrollees. Therefore, grievances pending and unresolved may reflect
9 enrollees pursuing their Medicare or Medi-Cal appeal rights."
10

11 c. The quarterly report shall include:
12

13 i. The licensee's name, quarter and date of the report;
14

15 ii. The total number of Grievances, received and resolved;
16

17 iii. Whether the Grievance was resolved in favor of the Member or CalOptima Health;
18

19 iv. The number of Grievances filed by Members that were or are Pending and
20 unresolved for more than thirty (30) calendar days at any time during the quarter.
21

22 v. The category of the Grievance as one of the following:
23

24 a) Commercial;
25

26 b) Medicare; and
27

28 c) Medi-Cal/other.
29

30 vi. A brief explanation of why the Grievance was not resolved in thirty (30) days,
31 and indicate whether the grievance was or is pending at:
32

33 a) CalOptima Health's internal Grievance system;
34

35 b) DMHC's consumer complaint process;
36

37 c) The IMR process;
38

39 d) Court; or
40

41 e) Other dispute resolution processes.
42

43 vii. Alternatively, CalOptima Health shall indicate whether the Grievance was or is
44 submitted to:
45

46 a) Medicare review and appeal system;
47

48 b) Medi-Cal Fair Hearing process; or
49

50 c) Arbitration.
51

52 viii. The nature of the unresolved Grievances as:

- a) Coverage disputes;
- b) Disputes involving medical necessity;
- c) Complaints about the quality of care;
- d) Complaints about access to care (including complaints about the waiting time for appointments);
- e) Complaints about the quality of service; and
- f) Other issues.

ix. The quarterly report shall not contain personal or confidential information with respect to any Member.

~~6.H.~~ CalOptima Health shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

~~7.I.~~ CalOptima Health Customer Service and GARS Departments' management staff shall, on a monthly basis, review reports for tracking and trending of Exempt Grievances by Provider, Health Network, and Grievance category.

~~8.J.~~ GARS shall present to the Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

~~9.K.~~ The written record of Grievances, including Exempt Grievances, shall be reviewed periodically by CalOptima Health's Board of Directors, the Member Advisory Committee, and Provider Advisory Committee, and the Chief Operating Officer or Designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code §§ 1365, 1367.01(e),(h)(3), and (j), ~~1367.24~~, 1368 (a)(1), (a)(4)(B), 1368.01(a)-(b), 1368.016, 1368.02(b), ~~1367.24~~, 1368.015, 1370.2, 1371.34, 1374.30 (e), (i), (j)(1) and (3) (l), (m), (n), 1374.31, 1374.34(a).

B. CalOptima Health Contract with Covered California

C. CalOptima Health Grievance Form For Cancellation, Rescission, Or Nonrenewal

D. CalOptima Health Grievance Acknowledgement Letter

E. CalOptima Health Grievance Resolution Letter

F. CalOptima Health Language Assistance Taglines

G. CalOptima Health Member Complaint Form Member Non-discrimination Notice

H. CalOptima Health Member Grievance Process

~~C.I.~~ CalOptima Health Policy CC.1200: Member Appeal Process

~~D.J.~~ CalOptima Health Policy DD.2002: Cultural and Linguistic Services

~~E.K.~~ CalOptima Health Policy GG.1611: Potential Quality Issue Review Process

F.L. CalOptima Health Policy HH.1104: ~~Complaints of~~ Discrimination and TGI-Related
Grievances
G.M. 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
N. CalOptima Health Urgent Grievance Acknowledgement (Downgrade) Letter
H.O. DMHC All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8,
2022)
H.P. Standards and Guidelines for the Accreditation of Health Plans
J.Q. Title 28, California Code of Regulations, §§ 1300.68(a), (a), (b)(3)-(b)(8), 1300.68.01, 1300.85,
1300.85.1-
K.R. Title 45, Code of Federal Regulations, § 156.122(c)-)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1201	Member Grievance	Covered California

IX. GLOSSARY

Term	Definition
Acknowledgment/ <u>Resolution</u> Letter	A written statement acknowledging receipt, <u>or resolution</u> , of a Grievance.
Adverse Benefit Determination <u>Appeal</u>	Any <u>A type of Grievance related to any</u> of the following <u>medical necessity determination or coverage</u> actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity<u>medical necessity</u>, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability.
Appeal <u>Process</u>	A review <u>The process by which</u> 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 and its Health Networks address and provide services in a timely manner; or 5. Failure to act within the timeframes required in CalOptima Health Policy CC.1200: Member<u>Resolution to all Appeals</u>Process.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian, or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance
Complaint/ <u>Complainant</u>	A complaint is the same as a Grievance, as defined below. <u>A Complainant is in the individual making or filing the Grievance.</u>

Term	Definition
<u>Coverage Decision</u>	<u>The approval or denial of health care services by CalOptima Health or a Health Network substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Member's CalOptima plan contract. A "coverage decision" does not encompass a CalOptima Health or Health Network decision regarding a disputed health care service.</u>
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.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations and other managed care plans.
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.
Disputed Health Care Service	Any health care service eligible for coverage and payment under a CalOptima Health plan contract that has been denied, modified, or delayed by a decision of CalOptima Health, or by one of its contracting Providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.
Exempt Grievance	Grievances received by telephone, fax, email, or online through CalOptima Health's internet website that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt
Grievance/ <u>Grievant</u>	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 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. <u>A Grievant is the individual making or filing the Grievance.</u>
Grievance Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
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.
<u>Interpret/Interpretation</u>	<u>The act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).</u>

Term	Definition
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	An individual enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Non-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
Non-Coverage Decision Resolution Letter (Organization Determination)	Any determination made by CalOptima Health with respect to any of the following: 1.—Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services; 2.—Payment for any other health services furnished by a Provider that the Member believes: a.—Are covered under CalOptima Health's Covered California plan; or b.—If not covered under CalOptima Health's Covered California plan, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3.—CalOptima Health's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged for by CalOptima Health; 4.—Reduction or premature discontinuation of a previously authorized service; or 5.—CalOptima Health's failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Pending	Grievances or Appeals that are not resolved within thirty (30) calendar days, or that are referred to the DMHC's complaint or independent medical review system or other external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, <u>as applicable.</u>
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

Term	Definition
Resolved/Resolution	The Grievance has reached a final conclusion with respect to the Member's submitted Grievance and there are no Pending Member appeals within CalOptima Health's Grievance system, including any entities with delegated authority.
Standard Grievance	A Grievance that does not meet the criteria to be treated as an Exempt or Urgent Grievance.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.
Trans-Inclusive Health Care	Comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex (TGI) and honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.
Urgent Grievance	Grievances that involve an imminent and serious threat to the mental or physical health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

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Policy: CC.1201
Title: **Member Grievance**
Department: Grievance and Appeals Resolution Services
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2027
Revised Date: Not Applicable

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

I. PURPOSE

This policy defines the process by which CalOptima Health's Grievance system addresses and resolves Grievances from a Member, or a Provider or Authorized Representative acting on behalf of a Member with the Member's written consent, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

- A. CalOptima Health shall establish and maintain a Grievance system pursuant to applicable federal and state laws and regulations, including the Knox-Keene Act and its implementing regulations. CalOptima Health's Grievance system is composed of the Grievance Process outlined in this policy and the Appeal Process outlined in CalOptima Health Policy CC.1200: Member Appeal Process. The Appeal Process applies to standard and expedited pre-service and post-service Appeals, which are a subset of Grievances that involve medical necessity determinations and coverage decisions. The Grievance Process outlines CalOptima Health's process for resolving Grievances that do not involve Medical Necessity determination or coverage decisions. Both the Appeal and Grievance Processes receive and resolve "Grievances", as that term is used under the Knox-Keene Act in accordance with the requirements therein.
- B. CalOptima Health shall establish and maintain a Grievance Process pursuant to which a Member, or a Provider or Authorized Representative acting on behalf of a Member with the Member's written consent, may submit a Grievance for review and Resolution either orally or in writing.
- C. CalOptima Health's Grievance Process shall address the receipt, handling, and disposition of a Member's Grievance, in accordance with applicable statutory, regulatory, and contractual requirements.
- D. A Member need not use the term "Grievance" for a Complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a Member declines to file a Grievance, the Complaint shall still be categorized as a Grievance.
- E. Members have the right to submit a Grievance against named individual(s), subcontractors, downstream subcontractors, or staff for failure to provide Trans-Inclusive Health Care. If a

Grievance Resolution on Trans-Inclusive Health Care is decided in the Member's favor, the Grievance and Appeals Resolution Services (GARS) specialist will notify the Human Resources (HR) or Provider Relations (PR) departments for those individuals that must retake the Trans-Inclusive Health Care cultural competency training.

1. Upon notification from GARS, HR (for employee-related Grievances) and/or PR (for Provider, vendor, and subcontractor related Grievances) will conduct and track re-training as follows:

a. The Transgender, Gender Diverse, Intersex (TGI) cultural competency re-training will be conducted within forty-five (45) calendar days of the notification and before the individual requiring re-training has direct contact with Members again.

F. CalOptima Health shall assist a Member requiring assistance with filing a Grievance, including, but not limited to, a Member with limited English proficiency, disabilities, or cultural needs.

G. CalOptima Health shall ensure prompt review and investigation of a Grievance. A Health Network may participate in the review and investigation of a Grievance.

H. CalOptima Health shall process expedited requests timely in instances where a Provider indicates, or CalOptima Health determines, that the standard timeframe may seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function (Urgent Grievance).

I. CalOptima Health shall ensure that the person making the final decision on the Grievance did not participate in any decisions related to the Grievance and they are not the subordinate of any person involved in the initial determination. If the Grievance is regarding the denial of an expedited resolution of an Appeal or involves clinical issues, the person making the final decision shall also have the clinical expertise in treating a Member's condition or disease in accordance with CalOptima Health Policy CC.1200: Member Appeal Process.

J. CalOptima Health shall refer all potential medical quality-of-care issues identified through the Grievance Process to the Quality Improvement (QI) Department for review.

K. CalOptima Health shall ensure that there is no discrimination against a Member, a Member's Authorized Representative, or Provider on the grounds that the individual filed a Grievance, as required by federal and state nondiscrimination law and in accordance with CalOptima Health Policy HH.1104: Discrimination and TGI-Related Grievances.

L. CalOptima Health shall inform a Member of their right to file a Grievance through CalOptima Health for at least one hundred eighty (180) calendar days following any incident to express dissatisfaction about any matter. Grievances shall be handled in accordance with CalOptima Health Policy CC.1200 Member Appeal Process.

1. A Member's Provider or Authorized Representative, acting on behalf of the Member with the Member's written consent, has the right to file a Grievance within the one hundred eighty (180) day timeframe specified above.

M. CalOptima Health shall inform a Member, during the Grievance Process, of their right to request a review by the Department of Managed Health Care (DMHC) after participating in the Grievance Process for thirty (30) days. CalOptima Health shall inform a Member that they may contact the DMHC at any time to request a review and do not have to participate in the Grievance Process for thirty (30) days if the Grievance:

1. Is an Urgent Grievance;
 2. Relates to cancellations, rescissions, or the nonrenewal of the Member's CalOptima contract; or
 3. Has been determined by the DMHC that an earlier review is warranted.
- M. For grievances involving delay, modification, or denial of services based on a determination in whole or in part that the service is not Medically Necessary, CalOptima Health shall inform a Member of their right to request an Independent Medical Review (IMR) in accordance with CalOptima Health Policy CC.1200: Member Appeal Process.
- N. CalOptima Health shall give a Member a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Grievance, evidence, testimony, facts, and law in support of the Grievance. CalOptima Health or a Health Network shall inform the Member of the limited time available to present evidence sufficiently in advance of the Resolution timeframes, including for Urgent Grievances.
- O. CalOptima Health shall consider all comments, documents, records, and other information submitted by the Member, or the Member's Authorized Representative or Provider, regardless of whether such information was submitted or considered during the initial review.
- P. CalOptima Health shall provide the opportunity, before and during the Grievance Process, to examine and or obtain a copy of the Member's case file, including the Medical Record, and any other relevant documents and records considered during the Grievance Process, upon request by the Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent. CalOptima Health shall provide records at no cost.
- Q. CalOptima Health and its Health Networks shall provide culturally and linguistically appropriate notices of the Grievance Process to Members, including language assistance taglines and a notice of non-discrimination in compliance with the requirements set forth by the DMHC, and in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- R. A Member, or a Provider or Authorized Representative acting on behalf of the Member with the Member's written consent, may submit a request to Appeal a decision not related to a utilization management decision with any supporting documentation to GARS. Such request shall be considered a Non-Coverage Appeal, and CalOptima Health shall process the request as a Grievance and in accordance with Section III.E. of this policy.
- S. CalOptima Health shall be available twenty-four (24) hours a day, seven (7) days a week to receive communications from the DMHC regarding Urgent Grievances.
1. During normal work hours, CalOptima Health shall respond to the DMHC within thirty (30) minutes after initial contact and within one (1) hour during non-work hours.
 2. CalOptima Health has designated plan representatives, including back-up plan representatives as necessary, who have the authority to resolve Urgent Grievances and authorize the provision of health care services in a medically appropriate and timely manner. Such authority includes making financial decisions for expenditure of funds on behalf of CalOptima Health without first having to obtain approval from supervisors or other superiors; however, the plan representative may consult with other plan staff on Urgent Grievances.

3. If CalOptima Health revises the staffing plan for DMHC to be able to contact a plan representative regarding Urgent Grievances, it shall notify the DMHC at least thirty (30) days in advance of implementing the revisions.

T. Responsible Staff

1. CalOptima Health's Chief Operating Officer shall have primary responsibility for:
 - a. Maintenance of the Grievance Process;
 - b. Review of the operations; and
 - c. Identification of any emerging or systemic issues of Grievances and Appeals and/or patterns of improper service denials in the formulation of policy changes and procedural improvements to CalOptima Health's administration of the program.
2. CalOptima Health's Director of GARS shall have primary responsibility for the oversight of the Grievance Process.

U. CalOptima Health shall maintain a Grievance system/platform that has the ability to:

1. Monitor the number of Grievances received and resolved, including whether the Grievance was resolved in favor of the Member of CalOptima Health, and the number of Grievances pending over thirty (30) calendar days.
2. Track grievances under categories of:
 - a. Commercial
 - b. Medicare
 - c. Medi-Cal/other contracts
3. Indicate whether a Member Grievance is pending at:
 - a. CalOptima's internal Grievance system;
 - b. DMHC's consumer complaint (review) process;
 - c. DMHC's IMR process;
 - d. An action filed or before a trial or appellate court; or
 - e. Other dispute resolution process.
4. Additionally, the system shall indicate whether a Grievance has been submitted to arbitration.
5. Indicate the total number of Grievances received, pending and resolved in favor of the Member at all levels of Grievance review and to describe the issue or issues raised in Grievances as (1) coverage disputes, (2) disputes involving medical necessity, (3) complaints about the quality of care, (4) complaints about access to care (including complaints about the waiting time for appointments), and (5) complaints about the quality of service, and (6) other issues.

III. PROCEDURE

- A. Unless otherwise specified, CalOptima Health shall resolve all possible levels of internal Grievances or Appeals within thirty (30) calendar days of the receipt of the Grievance.
- B. Assistance to Members
 - 1. CalOptima Health shall make Complaint forms and procedures for filing a Grievance available at each facility that provides Covered Services to Members, on CalOptima Health's website, and from each contracting Provider's office or facility.
 - 2. CalOptima Health shall promptly provide Complaint forms and procedures to a Member upon request.
 - 3. CalOptima Health's Customer Service Department shall assist a Member with questions regarding the procedures for filing Grievances and shall triage Member calls and route Grievances to the GARS Department via its electronic system.
 - 4. CalOptima Health shall ensure that Members accessing the Grievance system are given assistance in completing Grievance forms and other procedural steps, including but not limited to providing auxiliary aids and services upon request, such as Interpreter services and a toll-free number with TTY/TDD and Interpreter capability in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- C. Exempt Grievances
 - 1. Grievances received by telephone, that are not coverage disputes, Disputed Health Care Services involving medical necessity, or experimental or investigational treatment, and that are resolved by the close of the next business day are exempt from the requirement from sending a written acknowledgment and response and shall be classified as an Exempt Grievance.
 - 2. CalOptima Health Customer Service and GARS Departments shall maintain records and logs of Standard, Urgent, and Exempt Grievances, including the date of receipt, name of Complainant, Member's name and Member identification number, nature of the Grievance, name(s) of the CalOptima Health staff who received the Grievance, and name of the CalOptima Health staff who Resolved the Grievance.
 - 3. CalOptima Health Customer Service Department shall, on a monthly basis, provide an Exempt Grievance and "Declined Grievance" report to GARS to be aggregated for tracking and trending purposes as with other Grievances.
 - 4. A Member, a Member's Authorized Representative, or a Provider acting on behalf of a Member, may express dissatisfaction, or discontent, to the CalOptima Health Customer Service Department by telephone, or in person.
 - 5. The CalOptima Health Customer Service Department staff shall:
 - a. Identify and document the nature of the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of a Member;

- b. Document all actions taken to address the dissatisfaction expressed by the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member, as well as the Resolution provided in response to the dissatisfaction expressed by the Member, Member's Authorized Representative, or Provider acting on behalf of the Member; and
 - c. If the Grievance is Resolved by the close of the next business day, it shall be classified as an Exempt Grievance.
 6. If CalOptima Health Customer Service Department staff is unable to provide Resolution to the Member, a Member's Authorized Representative, or Provider acting on behalf of a Member regarding the dissatisfaction, or discontent by close of the next business day, the CalOptima Health Customer Service staff shall:
 - a. Educate the Member, Member's Authorized Representative, or Provider acting on behalf of a Member of Grievance rights in accordance with this Policy and inform them that the issue(s) will be referred to the CalOptima Health GARS Department;
 - b. Inform the Member, Member's Authorized Representative, or Provider acting on behalf of a Member of the Resolution timeframes; and
 - c. If the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member agrees to the Grievance referral, route the Grievance to the GARS Department.
 7. If the Member, Member's Authorized Representative, or Provider acting on behalf of a Member expressly declines to file the Grievance, Customer Service Department staff shall:
 - a. Categorize the issue as a Grievance;
 - b. Forward potential quality of care declined Grievances to the CalOptima Health QI Department for review;
 - c. Continue to assist the Member, Member's Authorized Representative, or a Provider acting on behalf of a Member until the Grievance is fully Resolved; and
 - d. Close the Grievance with the "Declined Grievance" disposition code.

D. Grievance Process

1. A Member, or Provider or Authorized Representative acting on behalf of the Member, may file a Grievance:
 - a. With CalOptima Health's Customer Service Department, by telephone, or in person; or
 - b. With CalOptima Health GARS, by facsimile, in writing, or through the CalOptima Health website at www.CalOptima.org.
2. GARS shall ensure that Members, or a Member's Provider or Authorized Representative, have equal access to, and can fully participate in, the Grievance process by providing assistance to Members, or a Member's Provider or Authorized Representative, with disabilities, limited English proficiency, vision disorders, or other communicative impairments by providing the following services in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

3. CalOptima Health shall provide language assistance for Threshold Languages and language line Interpretation services, as needed, to register and resolve Grievances in all other languages. CalOptima Health shall also translate Grievance correspondence into Threshold Languages and offer oral Interpretation for Grievance correspondence for all other languages in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
4. In the event an oral Grievance is received, CalOptima Health will process the Grievance regardless of whether a signed, written Grievance is subsequently received from the Member.
5. CalOptima Health shall process a Grievance for discrimination as required by applicable federal and state nondiscrimination laws and in accordance with CalOptima Health Policy HH.1104: Discrimination and TGI-Related Grievances.
6. Upon receipt of a Grievance, GARS shall:
 - a. Date stamp and document the substance of the Grievance, and any action taken, including but not limited to the Member's previous Complaint history and follow-up activities associated with the Complaint, in the GARS database, verifying demographics and network affiliation.
 - b. Determine the category of Grievance, including but not limited to:
 - i. quality of care;
 - ii. quality of service;
 - iii. access to care;
 - iv. and other, based on the Grievance.
 - c. Assign type and subtype descriptors, the responsible staff, and documentation of issue(s).d. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Grievance, indicating receipt of the Grievance, the date of receipt of the Grievance, and providing the name, telephone number and address of the GARS staff member whom the Member may contact regarding the Grievance, and provide the Member with an estimated completion date of Resolution. The Acknowledgment Letter shall also include information regarding a Member's right to participate in the Grievance process, as described in this policy.
 - d. Triage and investigate the Grievance, and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Grievance.
 - e. CalOptima Health shall take into consideration the Member's medical condition when determining the response time, particularly for Urgent Grievances, as described in this policy.
 - f. Refer all Grievances related to potential medical quality of care issues to the QI Department for immediate review by CalOptima Health's Chief Medical Officer (CMO) or their Designee and any action deemed necessary under the quality review process in accordance with CalOptima Health Policy GG.1611: Potential Quality Issue Review Process.

- 1 g. Review and immediately process all Grievances that may seriously jeopardize the
2 Member's life or health or ability to attain, maintain or regain maximum function (Urgent
3 Grievance), on an expedited basis and issue the decision within three (3) calendar days of
4 receipt. For Urgent Grievances, GARS shall:
5
6 i. Immediately notify the Member or their Authorized Representative of the shortened
7 timeframe to submit information related to their case the right to contact the DMHC
8 regarding the Urgent Grievance, and that there is no requirement to participate in
9 CalOptima Health's grievance process before applying to the DMHC for review of the
10 Urgent Grievance. Notification shall be made verbally and in writing by sending or
11 providing the Member with a hard copy of the Member Grievance Process, which
12 includes these Urgent Grievance rights.
13
14 ii. If a Member submits an Urgent Grievance to the DMHC for expedited review,
15 CalOptima Health shall notify the DMHC before changing or modifying any benefit or
16 services that relates to the Urgent Grievance if the Member or their Authorized
17 Representative objects to the change or modification.
18
19 iii. Take into consideration the Member's medical condition when determining the
20 response time.
21
22 iv. Provide a written statement to the DMHC and the Member on the disposition or
23 Pending status of the Urgent Grievance within three (3) calendar days of receipt of the
24 Grievance by CalOptima Health.
25

26 7. Processing of Grievances by Type:
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- 28 a. For Grievances involving contested claims, GARS shall refer the claim for review to a
29 licensed and competent health care professional to evaluate the clinical issues of the
30 appealed claim, as applicable.
31
32 b. Grievances for Pharmacy Services: A Member or the Member's Designee or guardian may
33 Appeal a denial of an exception request for coverage of a nonformulary drug, prior
34 authorization request, or step therapy exception request by filing a Grievance in accordance
35 with this policy pursuant to Health and Safety Code § 1367.24 and in compliance with (c)
36 of § 156.122 of Title 45 of the Code of Federal Regulations.
37
38 c. Grievances Related to Privacy Rights: CalOptima Health shall inform a Member of their
39 right to file a Grievance with CalOptima Health or with the Secretary of Health and Human
40 Services regarding violations of their privacy rights, in accordance with CalOptima Health
41 Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of
42 Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.
43
44 d. For Grievances involving the cancellation, rescission, or nonrenewal of a CalOptima Health
45 plan contract, CalOptima Health shall continue to provide coverage to the Member under
46 the terms of the CalOptima Health plan contract until a final determination of the Member's
47 request for review has been made by CalOptima Health, or the DMHC pursuant to Health
48 and Safety Code § 1365. This paragraph shall not apply if CalOptima Health cancels or fails
49 to renew the Member's health plan contract for nonpayment of premiums.
50

- 51 8. Upon resolution of a Standard Grievance, GARS shall send the Member, or Provider or
52 Authorized Representative acting on behalf of the Member and with the Member's written
53 consent, a Grievance Resolution Letter, not to exceed thirty (30) calendar days from the date

CalOptima Health receives the oral or written Grievance. The Grievance Resolution Letter shall describe the Grievance and provide a clear and concise explanation of the reasons for the decision, including but not limited to:

- a. Summary of the Member's Grievance;
 - b. The investigation made in the review process, including any referrals to the QI Department for medical quality of care review;
 - c. When possible, the outcome of the review; and
 - d. Alternative resources or references, when applicable.
 - e. If the resolution includes an adverse decision, information regarding the Member's right to Appeal.
 - f. For Grievances involving the delay, denial, or modification of services, based on a determination in whole or in part that the service is not medically necessary, the Grievance Resolution Letter shall also describe the following:
 - i. The criteria used and the clinical reasons for CalOptima Health's decision; and
 - ii. The provisions in the Member's CalOptima Health plan contract and/or the Member's Evidence of Coverage that exclude coverage of the specified benefit.
9. GARS staff shall close the case in the GARS database by documenting the disposition of the Grievance, including whether the Grievance was resolved in favor of the Member or CalOptima Health, reviewing entity(ies), decision and any additional action taken (if any), include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member and save the electronic file.

E. Non-Coverage Appeals

1. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a request to Appeal a decision not related to a utilization management decision with any supporting documentation to GARS. This type of Grievance is considered a Non-Coverage Appeal and is separate from the Appeal process in CalOptima Health Policy CC.1200: Member Appeal Process.
2. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may file the Non-Coverage Appeal with CalOptima Health's Customer Service Department by telephone or in person, or with GARS via facsimile, in writing or through the CalOptima Health Website at www.CalOptima.org.
3. CalOptima Health shall provide language assistance by CalOptima Health staff for Threshold Languages and language line Interpretation services, as needed, to register and resolve Grievances in all other languages.
4. The CMO or their Designee not involved in the initial review shall conduct the review of the decision.
5. Upon receipt of the Non-Coverage Appeal, GARS shall:

- a. Date stamp and document the substance of the Non-Coverage Appeal, including the member's reason for appealing the previous decision, and any action taken, into its electronic system, verifying demographics and network affiliation;
- b. Determine the category of the Non-Coverage Appeal based on the Grievance, assign type and subtype descriptors, the responsible staff, and documentation of issue(s), and any follow-up activities related to the Non-Coverage Appeal;
- c. Send the Member an Acknowledgment Letter within five (5) calendar days after receipt of a Non-Coverage Appeal, indicating the date of receipt of the Grievance and identifying a GARS staff member whom the Member may contact regarding the Non-Coverage Appeal;
- d. Triage and investigate the Non-Coverage Appeal and, as necessary, consult with the CalOptima Health department or Health Network responsible for the services or operations that are the subject of the Complaint;
- e. Refer all Non-Coverage Appeals related to potential quality of care issues to the QI Department for review by the CalOptima Health CMO or their Designee and any action deemed necessary under the quality review process;
- f. Review and immediately process all Non-Coverage Appeals involving an imminent and serious threat to the health of a Member including, but not limited to, severe pain or potential loss of life, limb, or major bodily function, on an expedited basis for effectuation of the decision within three (3) calendar days of receipt:
 - i. CalOptima Health shall expedite its review of the Urgent Grievance when a Member, an Authorized Representative, or treating physician provides notice to CalOptima Health. Notice need not be in writing but may be accomplished by a documented telephone call.
- g. Notify the Member of the Non-Coverage Appeal decision in writing within thirty (30) calendar days of the receipt of the Grievance and include the next level appeal rights attachments including the right to file a Complaint with DMHC.
 - i. CalOptima Health shall provide language assistance, by CalOptima Health staff for Threshold Languages and language line Interpretation services, as needed to register and resolve Grievances in all other languages.
 - ii. For Grievances appealing Non-Coverage Appeal decisions, including but not limited to requests for access to out-of-network Providers or change of Health Networks, the Grievance Resolution Letter shall include:
 - a) Summary of the Member's Non-Coverage Appeal;
 - b) Description of actions taken to review the request;
 - c) Date and name of position of staff involved in the review; and
 - d) Date of the issuance of the decision.
 - e) Information regarding the Member's right to further Appeal, as appropriate, including the right to file a Complaint with DMHC.

6. CalOptima Health shall take immediate action to implement the decision, in accordance with the Grievance Resolution Letter and in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Services Requiring Prior Authorization.
7. GARS staff shall close the case in its electronic system by documenting the disposition of the Non-Coverage Appeal, reviewing entity(ies), decision and any additional action taken (if any), and include a copy of the Grievance Resolution Letter and document any oral notification provided to the Member, and Resolution date.

F. DMHC Review Process

1. A Member shall not be required to participate in CalOptima Health's Grievance Process:
 - a. For more than thirty (30) days for Standard Grievances;
 - b. For more than three (3) days, for Urgent Grievances that require expedited review; or,
 - c. When the DMHC determines that the case involves an imminent and serious threat to the health of the Member, including, but not limited to:
 - i. severe pain, the potential loss of life, limb, or major bodily function;
 - ii. cancellations, rescissions, or the nonrenewal of the health plan contract; or
 - iii. in any other case where the DMHC determines that extraordinary and compelling circumstances exist and an earlier review is warranted.
2. A Member or Authorized Representative may submit a Grievance to the DMHC for review and resolution prior to any arbitration.
3. A Member or Authorized Representative may authorize a Provider to assist the Member in submitting the Grievance to the DMHC and advocating on behalf of the Member.
4. In any case in which a Member or Provider asserts that a decision to deny, modify, or delay health care services was based, in whole or in part, on consideration of medical necessity, the DMHC shall have the final authority to determine whether the Grievance is more properly resolved pursuant to an IMR or DMHC review. The DMHC shall also have final authority to determine whether a Grievance is a Disputed Health Care Service or a Coverage Decision.
5. If DMHC determines that a Grievance qualifies for IMR, CalOptima Health shall follow the IMR process outlined in CalOptima Health Policy CC:1200 Member Appeal Process.
6. Upon notice from the DMHC that a Member has submitted a Grievance to the DMHC for review, CalOptima shall provide the following information to the DMHC within five (5) calendar days after notification:
 - a. A written response to the issues raised by the Grievance.
 - b. A copy of CalOptima Health's original response sent to the Member regarding the Grievance.
 - c. A complete and legible copy of all medical records related to the Grievance. CalOptima

Health shall inform the DMHC if medical records were not used in resolving the Grievance.

- d. A copy of the cover page and all relevant pages of the Member's Evidence of Coverage (EOC), with the specific applicable sections underlined. If CalOptima Health relied solely on the EOC, it shall notify the DMHC of that fact.
 - e. All other information used by CalOptima Health or relevant to the resolution of the Grievance.
 - f. If the DMHC requests additional information or medical records, CalOptima Health shall forward information and records that are maintained by CalOptima Health or any contracting provider within five (5) calendar days of receipt of the DMHC's request. If requested information cannot be timely forwarded to the DMHC, CalOptima Health's response shall describe the actions being taken to obtain the information or records and when receipt is expected.
7. If the DMHC reviews a Grievance involving a Disputed Health Care Service, as defined in Health and Safety Code §1374.30(b), that is not eligible for IMR and finds that CalOptima Health has delayed, denied, or modified health care services that are Medically Necessary, based on the specific medical circumstances of the Member, and those services are a covered benefit under the terms and conditions of the CalOptima Health plan contract, CalOptima Health shall comply with the DMHC's binding order and written notice to:
- a. Promptly offer and provide those health care services to the Member; or,
 - b. Promptly reimburse the Member for any reasonable costs associated with Urgent Care or Emergency Services, or other extraordinary and compelling health care services, when the DMHC finds that the Member's decision to secure those services outside of the CalOptima Health network was reasonable under the circumstances.

G. Notices, Records, and Reports

1. Upon enrollment, and annually thereafter, CalOptima Health shall inform a Member, in writing, of the locations for filing a Grievance, telephone numbers where a Grievance may be submitted, related procedures regarding the Grievance Process, information regarding the DMHC review process, the Independent Medical Review system, and the DMHC's toll-free telephone number and website address. CalOptima Health shall provide these notices in Threshold Languages, as required by the DMHC and Covered California.
2. CalOptima Health shall keep in its files written records of each Grievance, including copies of Grievance records of any sub-contracting entity delegated the responsibility to maintain and resolve Grievances. The records shall include all Medical Records, documents, evidence of coverage and other relevant information upon which the plan relied in reaching its decision, the date and time of receipt, Member's name, description of the Complaint or problem, names of the CalOptima Health staff who received the Grievance and who is designated as the contact person, description of the action taken to investigate/resolve the problem, Resolution proposed by GARS or the medical professional responsible for making a utilization management decision, the name of the CalOptima Health Provider or staff responsible for resolving the Grievance, the date of notification to the Member of Resolution, and all Grievance Resolution Letters. CalOptima Health shall maintain the written records, for a minimum of ten (10) years.

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3. CalOptima Health shall continually evaluate and analyze Grievance data to identify systemic patterns of improper services denials and other trends impacting health care delivery to Members.
 4. On a quarterly basis, CalOptima Health shall submit all recorded Member Grievances related to access to care, quality of care, and denial of services to the QI Committee to review and take appropriate action to remedy any problems identified in such reviews.
 5. Aging Grievances Report. CalOptima Health's Grievance system shall track and document aging Grievances, which are Grievances that are Pending and unresolved for thirty (30) calendar days or more. CalOptima Health shall provide a quarterly report to the DMHC of Grievances Pending:
 - a. The report shall be verified by CalOptima Health's Director of GARS and submitted as specified in Title 28, California Code of Regulations § 1300.68(i).
 - b. CalOptima Health may request the DMHC to include the following statement in the quarterly report that is made public: "Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights."
 - c. The quarterly report shall include:
 - i. The licensee's name, quarter and date of the report;
 - ii. The total number of Grievances, received and resolved;
 - iii. Whether the Grievance was resolved in favor of the Member or CalOptima Health;
 - iv. The number of Grievances filed by Members that were or are Pending and unresolved for more than thirty (30) calendar days at any time during the quarter.
 - v. The category of the Grievance as one of the following:
 - a) Commercial;
 - b) Medicare; and
 - c) Medi-Cal/other.
 - vi. A brief explanation of why the Grievance was not resolved in thirty (30) days, and indicate whether the grievance was or is pending at:
 - a) CalOptima Health's internal Grievance system;
 - b) DMHC's consumer complaint process;
 - c) The IMR process;
 - d) Court; or
 - e) Other dispute resolution processes.

vii. Alternatively, CalOptima Health shall indicate whether the Grievance was or is submitted to:

- a) Medicare review and appeal system;
- b) Medi-Cal Fair Hearing process; or
- c) Arbitration.

viii. The nature of the unresolved Grievances as:

- a) Coverage disputes;
- b) Disputes involving medical necessity;
- c) Complaints about the quality of care;
- d) Complaints about access to care (including complaints about the waiting time for appointments);
- e) Complaints about the quality of service; and
- f) Other issues.

ix. The quarterly report shall not contain personal or confidential information with respect to any Member.

H. CalOptima Health shall submit on a quarterly basis aggregate and detailed Grievance data to the Quality Assurance Committee.

I. CalOptima Health Customer Service and GARS Departments' management staff shall, on a monthly basis, review reports for tracking and trending of Exempt Grievances by Provider, Health Network, and Grievance category.

J. GARS shall present to the Quality Improvement Health Equity Committee (QIHEC) on a quarterly basis any trends identified including those related to health inequities, implicit bias, and discrimination. GARS will update the QIHEC on any actions taken by the GARS Committee.

K. The written record of Grievances, including Exempt Grievances, shall be reviewed periodically by CalOptima Health's Board of Directors, the Member Advisory Committee, and Provider Advisory Committee, and the Chief Operating Officer or Designee, all who have the authority to require corrective action. The review and recommendations of such shall be thoroughly documented.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Health and Safety Code §§ 1365, 1367.01(e),(h)(3), and (j), 1367.24, 1368 (a)(1), (a)(4)(B), 1368.01(a)-(b), 1368.016, 1368.02(b), 1368.015, 1370.2, 1371.34, 1374.30 (e), (i), (j)(1) and (3) (l), (m), (n), 1374.31, 1374.34(a).

- B. CalOptima Health Contract with Covered California
C. CalOptima Health Grievance Form For Cancellation, Rescission, Or Nonrenewal
D. CalOptima Health Grievance Acknowledgement Letter
E. CalOptima Health Grievance Resolution Letter
F. CalOptima Health Language Assistance Taglines
G. CalOptima Health Member Complaint Form Member Non-discrimination Notice
H. CalOptima Health Member Grievance Process
I. CalOptima Health Policy CC.1200: Member Appeal Process
J. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
K. CalOptima Health Policy GG.1611: Potential Quality Issue Review Process
L. CalOptima Health Policy HH.1104: Discrimination and TGI-Related Grievances
M. 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
N. CalOptima Health Urgent Grievance Acknowledgement (Downgrade) Letter
O. DMHC All Plan Letter (APL) 22-021: Quarterly Grievance Reports (Revised November 8, 2022)
P. Standards and Guidelines for the Accreditation of Health Plans
Q. Title 28, California Code of Regulations, §§ 1300.68(a), (a), (b)(3)-(b)(8), 1300.68.01, 1300.85, 1300.85.1
R. Title 45, Code of Federal Regulations, § 156.122(c)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
06/05/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1201	Member Grievance	Covered California

1 IX. GLOSSARY
2

Term	Definition
Acknowledgment/Resolution Letter	A written statement acknowledging receipt, or resolution, of a Grievance.
Appeal	A type of Grievance related to any of the following medical necessity determination or coverage actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability.
Appeal Process	The process by which CalOptima Health and its Health Networks address and provide Resolution to all Appeals.
Authorized Representative	For purposes of this policy, an individual appointed by a Member, or a Member's parent, guardian, or other party, or authorized under State or other applicable law, to act on behalf of a Member involved in an Appeal or Grievance
Complaint/Complainant	A complaint is the same as a Grievance, as defined below. A Complainant is in the individual making or filing the Grievance.
Coverage Decision	The approval or denial of health care services by CalOptima Health or a Health Network substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Member's CalOptima plan contract. A "coverage decision" does not encompass a CalOptima Health or Health Network decision regarding a disputed health care service.
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.
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations and other managed care plans.
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.
Disputed Health Care Service	Any health care service eligible for coverage and payment under a CalOptima Health plan contract that has been denied, modified, or delayed by a decision of CalOptima Health, or by one of its contracting Providers, in whole or in part due to a finding that the service is not medically necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision.

Term	Definition
Exempt Grievance	Grievances received by telephone, fax, email, or online through CalOptima Health's internet website that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt
Grievance/Grievant	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 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. A Grievant is the individual making or filing the Grievance.
Grievance Process	The process by which CalOptima Health and its Health Networks address and provide resolution to all Grievances.
Grievance Resolution Letter	A written statement explaining the disposition of a Grievance based on a review of the facts, relevant information, and documentation.
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.
Interpret/Interpretation	The act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).
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	An individual enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Non-Coverage Appeal	Grievances about decisions that are not related to utilization management decisions.
Pending	Grievances or Appeals that are not resolved within thirty (30) calendar days, or that are referred to the DMHC's complaint or independent medical review system or other external review processes, such as reviews of Medicare Managed Care determinations pursuant to 42 C.F.R. Part 422, or the Medi-Cal Fair Hearing process, as applicable.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.

Term	Definition
Resolved/Resolution	The Grievance has reached a final conclusion with respect to the Member's submitted Grievance and there are no Pending Member appeals within CalOptima Health's Grievance system, including any entities with delegated authority.
Standard Grievance	A Grievance that does not meet the criteria to be treated as an Exempt or Urgent Grievance.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.
Trans-Inclusive Health Care	Comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex (TGI) and honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.
Urgent Grievance	Grievances that involve an imminent and serious threat to the mental or physical health of the Member, including but not limited to severe pain, potential loss of life, limb or major bodily function, or lack of timeliness that could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

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Policy: DD.2006b
Title: **Member Primary Care Provider and Health Network Selection/Assignment**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2011

Revised Date:

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

I. PURPOSE

This policy describes the criteria by which a CalOptima Health Member shall select or be assigned a Health Network and Primary Care Provider (PCP).

II. POLICY

A. ~~CalOptima Health~~ CalOptima Health is committed to a Health Network Eligible Member's right to choose a Health Network. CalOptima Health also recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP and Health Network.

B. As part of CalOptima Health's commitment to these objectives, CalOptima Health shall assign the Member to a participating PCP and Health Network in accordance with this policy.

1. Unless otherwise specified by this policy, Health Network Eligible Members may select or be assigned to any participating PCP and Health Network currently accepting new Members.

2. Covered California: Members will be assigned to a PCP and Health Network upon receipt of the binder premium payment (Effectuation) by CalOptima Health.

3. American Indian Members may choose an American Indian Health Care Provider within CalOptima Health's provider network as their Primary Care Provider.

4. Medi-Cal: Members less than twenty-one (21) years of age may select Children's Hospital of Orange County (CHOC) Health Alliance as their Health Network.

5. Medi-Cal: A Member who is known to be participating in California's Children's Services (CCS) may only enroll in a Health Network that is participating in the Whole-Child Model program.

C. A Health Network Eligible Member shall be subject to the Auto-Assignment process no later than the Member's effective date of coverage with CalOptima Health, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

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2 1. Members with a Medicare Advantage Plan or have Medicare Part B are not subject to auto-
3 assignment and will be assigned to COD.
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5 **D. Medi-Cal:** CalOptima Health recognizes that Family Linked Members may be best served by a
6 single Health Network to ensure coordinated delivery of services by a Provider who is
7 knowledgeable about the diverse needs of all the Members in the family. To facilitate this objective,
8 CalOptima Health shall assign a Family Linked Member whose family includes a Member already
9 enrolled in a Health Network to that Health Network in accordance with CalOptima Health Policy
10 AA.1207a: CalOptima Health Auto-Assignment.
11

12 1. CalOptima Health shall assign a Family Linked Member to the same PCP and Health Network
13 their youngest sibling if such Family Linked Member is under the age of twenty-one (21) years.
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15 2. If a Family Linked Member is over the age of twenty-one (21) years and their youngest sibling
16 is enrolled in CHOC Health Alliance, CalOptima Health shall assign the Family Linked
17 Member to the Health Network of another family Member, if applicable.
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19 3. If the Member is known to be eligible with the Whole-Child Model program/California
20 Children's Services Program (CCS) and the Member's youngest sibling is assigned to a PCP
21 and Health Network that does not participate in the WCM/CCS program, the Family Link
22 process will not apply.
23

24 ~~C.E.~~ CalOptima Health shall only assign a Member to a participating PCP who has been credentialed as
25 a PCP by CalOptima Health or a Health Network.
26

27 ~~D.F.~~ A Member shall have the right to select a participating Community Health Center or Non-
28 Physician Medical Practitioner as ~~his or her~~ their PCP.- If a Member chooses a participating Non-
29 Physician Medical Practitioner as ~~his or her~~ their PCP, the Member shall be assigned directly to the
30 supervising physician and not the Non-Physician Medical Practitioner.
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32 ~~E.G. Medi-Cal:~~ A Member categorized as a Senior or Person with a Disability (SPD) shall have the
33 right to choose a PCP specialist physician who is a participating Provider, is willing to perform the
34 role of the PCP, and has met CalOptima Health's requirements for a specialist to act as a PCP.
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36 ~~F.H. Medi-Cal:~~ A Member eligible for the California Children's Services (CCS) Program, or the
37 Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s),
38 shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and
39 is a CCS-paneled Provider qualified to treat the required range of CCS-Eligible Conditions of the
40 CCS child or youth, in accordance with CCS program rules and regulations.
41

42 ~~G.I. Medi-Cal:~~ CalOptima Health shall maintain the existing PCP assignment process for the Adult
43 Expansion Population by designating a point of contact to coordinate with county uninsured
44 programs and public health care systems to share data and use that data to effectuate PCP
45 assignments.
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47 1. CalOptima Health shall identify unique individuals in the county uninsured programs or public
48 health care systems by Client Index Number (CIN). If the CIN is not available, other data
49 elements shall be used such as name, date of birth, and address.
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51 2. CalOptima Health shall send the Member PCP Assignment file with all the data elements
52 outlined in the data transmission requirements, outlined in DHCS APL 23-031: Medi-Cal

Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition, to the county uninsured programs and public health care systems.

3. CalOptima Health shall receive data for the Adult Expansion Population from county uninsured programs and public health care systems to match PCP assignments for new and transitioning Members. CalOptima Health shall use the data elements provided to complete a Member match and PCP assignment.
4. CalOptima Health shall return the PCP Assignment Return File to the county uninsured programs and/or public health systems of the Members successfully assigned a PCP match.
5. CalOptima Health shall not preclude assignment based on a PCP having a closed panel or not accepting new Members.
6. CalOptima Health shall receive, store, use, or transmit PHI and share data, in accordance with CalOptima Health Policy HH.3023: Information Sharing.
7. CalOptima Health shall securely destroy data for individuals who do not ultimately enroll into CalOptima Health, in accordance with CalOptima Health Policy GA.3201: Document Management Program and with Health Insurance Portability and Accountability Act (HIPAA) regulations.

~~H.J.~~ CalOptima Health shall make reasonable efforts to ensure that a Member expressing a desire to continue ~~his or her~~their existing relationship with a participating PCP is assigned to such PCP.

~~I.K.~~ A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as ~~his or her~~their PCP:

1. Shall be assigned directly to the FQHC or RHC; and
2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.

~~J.~~ ~~American Indian Members may choose an American Indian Health Care Provider within CalOptima Health's contracted network as his or her PCP.~~

~~K.L.~~ CalOptima Health shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.

~~L.M.~~ A Member may request a change his or her to their participating PCP ~~once every thirty (30) calendar days~~and/or health network at any time in accordance with this policy.

~~M.N.~~ **Medi-Cal:** CalOptima Health shall notify the CalOptima Health Community Network (CHCN) PCP via the provider portal that they have been selected by a Member, or that they have been assigned a Member by CalOptima Health, within ten (10) calendar days after completion of the selection or assignment.

~~N.O.~~ CalOptima Health shall notify the Health Networks of a PCP and/or health network assignment via the daily and monthly eligibility file.

~~O.P.~~ **Medi-Cal:** If a participating PCP terminates the contractual relationship with CHCN, CalOptima Health shall assign impacted Members to a new PCP of the Member's choice. In the absence of Member choice, if the PCP requests to maintain the relationship with the Member, the Member shall be assigned to a Health Network of the PCP's choice.

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1. Members diagnosed with the following conditions shall remain with CHCN and may continue with their current PCP if the PCP is contracted to see Members with the conditions outlined below. If the PCP is not contracted with CalOptima Health, the Member shall be assigned to a new PCP of the Member's choice or auto assigned in the absence of Member choice:
 - a. Diagnosed with hemophilia;
 - b. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) Primary Aid Code;
 - c. Listed for a Major Organ Transplant or approved for a Bone Marrow Transplant (BMT);
 - d. Has received a Major Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima Health; or
 - e. Is diagnosed with End Stage Renal Disease (ESRD).

19 Q. CalOptima Health or Health Networks shall be responsible for providing Covered Services to its
20 Members, in accordance with its contract and applicable statutes, regulations, CalOptima Health
21 policies, and other requirements of the CalOptima Health program.

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1. If a Health Network Eligible Member moves outside of Orange County, the assigned Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima Health program.
 2. **Medi-Cal:** If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, the assigned Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator/Public Guardian submits a request to change the Member in CalOptima Health Direct, in accordance with CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
 3. **Medi-Cal:** If Member becomes the responsibility of the Foster Care Program, the assigned Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County Children & Family Services Department may request to transition the Member into CalOptima Health Direct (COHD) – Administrative (COHD-A), in accordance with CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.

41 R. CalOptima Health or Health Networks shall ensure Continuity of Care for Members who transition
42 into CalOptima Health in accordance with CalOptima Health Policies CC.1500: Continuity of Care
43 for Members Transitioning into CalOptima Health and GG.1325: Continuity of Care for Members
44 Transitioning into CalOptima Health Services.

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S. In the event that a Member is required to change Health Networks, due to Health Network termination, CalOptima Health and the receiving Health Network shall collaborate to coordinate the provision of Covered Services for the affected Member, in accordance with CalOptima Health Policies CC.1501: Continuity of Care During Health Network or Provider Termination and GG.1304: Continuity of Care During Health Network or Provider Termination.

~~P.T.~~ CalOptima Health shall provide written notice of termination of a contracted PCP and/or Health Network to each Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

III. PROCEDURE

A. PCP and Health Network Selection or Assignment for a Newly Enrolled Member

1. ~~CalOptima Health~~ Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS) or Covered California, CalOptima Health shall ensure that a Member is assigned to a PCP and Health Network ~~and PCP~~ no later than the Member's effective date of coverage with CalOptima Health.
2. **Medi-Cal:** CalOptima Health shall create/update the Member's profile status in Facets and assign the Member to a participating PCP based on the following criteria: and Health Network in accordance with CalOptima Health policy AA.1207a: CalOptima Health Auto Assignment.
 - ~~a. If the Member was eligible with CalOptima Health within the last three hundred sixty-five (365) calendar days and an Adult Expansion Population Member's PCP data is received from the county uninsured programs and public health care systems, CalOptima Health shall assign the Member to the last PCP on record that listed in the PCP Assignment File.~~
 - ~~a.3. Covered California:~~ CalOptima Health shall create/update the member's profile status in Facets to "pending" until the binder payment is ~~currently~~ received by CalOptima Health. Once binder payment is received and Member has been effectuated, the Member shall be assigned to a participating PCP and Health Network in accordance with the Member's previous health network. If the PCP is no longer available, CalOptima Health shall assign the Member to a new PCP with the Members's previous policy AA.1207a: CalOptima Health Network Auto Assignment:
 - ~~b. A. If the Member was not eligible with CalOptima Health within the last three hundred sixty-five (365) calendar days and has an eligible family Member, CalOptima Health shall assign the Member to the same PCP and Health Network as the family member, subject to any age and/or gender restrictions required by the PCP.~~
 - ~~3. In the event Sections III.A.2. do not apply, CalOptima Health shall assign the Member to a participating PCP open for new assignment based on the following:~~
 - ~~a. The Member's age.~~
 - ~~b. Language.~~
 - ~~c. A. The geographic location of the participating PCP's office in relation to the Member's residence, in accordance with CalOptima Health Policy GG.1600: Access and Availability Standards.~~
 - ~~d. If more than one (1) PCP meets all assignment criteria, a PCP will be assigned based on a rotation to allow balanced distribution.~~
4. CalOptima Health shall notify a Member, in writing of the Member's Health Network and PCP assignment within ten (10) calendar days after completion of the assignment, with instructions on how the Member may request to change his or her ~~their~~ participating PCP and/or Health Network.

- 1 5. A Member may request to change ~~his or her~~their PCP ~~every thirty (30) calendar days by~~
2 ~~contacting CalOptima Health's Customer Service Department or by requesting the and/or~~
3 ~~Health Network change via CalOptima Health's secure Member portal at any time by:~~
4
- 5 a. ~~If the~~ **Medi-Cal:** Completing a PCP/Health Network Selection Form;
6
- 7 i. ~~Only a Health Network Eligible Member requests a PCP change before seeing his or her~~
8 ~~assigned PCP prior to the sixteenth (16th) calendar day or the Member's Authorized~~
9 ~~Representative shall sign a Health Network Selection Form on behalf of the current~~
10 ~~month, Member. If a Health Network Selection Form is not signed, CalOptima Health~~
11 ~~staff shall make contact the Member or the change effective Member's Authorized~~
12 ~~Representative and attain a verbal attestation.~~
13
- 14 a.ii. ~~If CalOptima Health receives a Health Network Eligible Member's completed Health~~
15 ~~Network Selection Form by the first (1st) tenth (10th) calendar day of a month, the~~
16 ~~current Member shall be enrolled into the selected Health Network no later than the first~~
17 ~~(1st) calendar day of the immediately following month. If CalOptima Health receives a~~
18 ~~Member's completed Health Network Selection Form after the tenth (10th) calendar day~~
19 ~~of the month, the Member shall be enrolled into the selected Health Network no later~~
20 ~~than the first (1st) calendar day of the month after the immediately following month.~~
21
- 22 b. ~~If the Member requests a PCP change after seeing his or her assigned PCP after the~~
23 ~~sixteenth (16th) calendar day of the current month, CalOptima Health shall make the~~
24 ~~change effective the first (1st) calendar day of the immediately following month.~~
25
- 26 b. ~~If an Adult Expansion Population Member's PCP data~~ Contacting CalOptima Health's
27 Customer Service Department or
28
- 29 c. Submit request via CalOptima Health's secure Member portal.
30
- 31 6. **Medi-Cal:** The PCP and/or Health Network change will be effective on the 16th of the month if
32 the request is received by the 15th of the month or the 1st of the following month if the request is
33 received after the 15th of the month.
34
- 35 7. **Covered California:** The PCP and/or Health Network change will be effective on the 1st of the
36 following month from the date of the request.
37
- 38 8. Members or their authorized representative may request an earlier effective date if they were
39 auto-assigned but prefer to continue with a provider with whom they have an established
40 relationship.
41
- 42 9. If a Member or authorized representative requests an earlier effective date for other reasons,
43 Customer Service staff shall:
44
- 45 a. Forward the request to Provider Network/Health Network Provider Relations who will
46 submit it to the Health Network for review.
47
- 48 b. If the request is approved by the Health Network, the change will be processed with the
49 effective date specified in the request.
50
- 51 c. If the Health Network denies the request, Customer Service will notify the member or
52 authorized representative and provide assistance with selecting and alternative another PCP
53 and/or Health Network.

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2 10. If a Member selects a participating PCP that has a closed panel or is not accepting new
3 Members, CalOptima Health shall:

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5 a. Inform the Member to choose another participating PCP.

6
7 b. ~~county uninsured programs and public health care systems~~ If a Member expresses that they
8 have an established relationship with a participating Primary Care Provider (PCP), before
9 proceeding with the change request, CalOptima Health shall confirm the panel closure is
10 not related to quality issues and contact the PCP to confirm the acceptance.

11
12 6.c. If a PCP or Health Network submits an acceptance letter requesting a Member assignment
13 to a closed their panel and attesting that the Member is in agreement with the change,
14 CalOptima Health shall assign the ~~member~~ Member to the PCP listed ~~ineffective~~ the PCP
15 Assignment File, first (1st) of the following month.

16
17 B. ~~For a PCP who~~ Medi-Cal: Members eligible for enrollment in CHOC Health Alliance

18
19 1. Subject to other limitations set forth in this policy, a Member who meets criteria set forth in
20 Section II.B.4. of this policy may select CHOC Health Alliance.

21
22 2. CalOptima Health shall assign a new Health Network Eligible Member to CHOC Health
23 Alliance, in accordance with Section III.A.2. of this policy.

24
25 3. A Member who is enrolled in CHOC Health Alliance shall select another Health Network prior
26 to his or her twenty-first (21st) birthday in accordance with the following:

27
28 a. CalOptima Health shall provide the Member with a ninety (90), sixty (60) and thirty (30)
29 calendar day written notice to select another Health Network prior to the Member's twenty-
30 first (21st) birthday. The written notices shall inform the Member that CHOC will only
31 provide health care service until the end of the Member's twenty-first (21st) birth month.

32
33 b. If the Member does not select another Health Network within the designated timeframe,
34 CalOptima Health shall assign the Member to a Health Network as follows:

35
36 i. If the Member's PCP is contracted with another Health Network, CalOptima Health
37 shall assign the Member to a Health Network of the Member's PCP's choice; or

38
39 ii. If the Member's PCP is not contracted with another Health Network, CalOptima Health
40 shall assign the Member to a Health Network and PCP based on geographic access.

41
42 c. The Member shall be enrolled in CHCN or the new Health Network effective the first (1st)
43 calendar day of the month immediately following the Member's twenty-first (21st)
44 birthday.

45
46 4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st)
47 birthday if the Member meets all of the following criteria:

48
49 a. Diagnosed with one (1) of the following California Children's Services (CCS)-Eligible
50 Conditions:

51
52 i. Cystic Fibrosis;

1
2 ii. A rare metabolic disorder not including Phenylketonuria (PKU);

3
4 iii. Spina Bifida; or

5
6 iv. Muscular Dystrophy.

7
8 b. Eligible to receive services from CCS for the CCS-Eligible Condition as of the day before
9 the Member's twenty-first (21st) birthday; and

10
11 c. Receiving care for the CCS-Eligible Condition from a pediatric specialist who is contracted
12 with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.

13
14 5. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy
15 shall remain in CHOC Health Alliance until:

16
17 a. The Member selects CHCN or another Health Network; or

18
19 b. The Member's pediatric specialist determines that the Member's care may safely be
20 transitioned to CHCN or another Health Network.

21
22 C. If a PCP terminates from participation with a Health Network, or if a Health Network terminates its
23 contract with CalOptima Health, CalOptima Health shall provide written notification to affected
24 Members at least thirty (30) calendar days prior to the effective date of the contract termination. in
25 accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or
26 Availability of Providers or Covered Services.

27
28 B.D.Medi-Cal: If a PCP terminates with CHCN, is available with other and contracted with other
29 Health Networks, and requests to maintain the relationship with the Member;

30
31 1. The ~~Provider~~PCP shall submit a written request to CalOptima Health's Provider Relations
32 Department at least ninety (90) calendar days prior to the expected date of termination;
33 including. The written request must state the PCP's intention to continue the relationship with
34 the Members and specify the name of the Health Network name for Member which the PCP is
35 seeking assignment as appropriate.

36
37 2. CalOptima Health shall provide written notification to the Member thirty (30) calendar days
38 prior to the effective date of the contract termination in accordance with CalOptima Health
39 Policy DD.2012: Member Notification of Change in Location or Availability of Providers or
40 Covered Services.

41
42 ~~3.1. If the Provider is contracted with CalOptima Health to continue seeing Members with certain~~
43 ~~diagnosis as described in Section II.O.1. of this policy, no change in Member's PCP assignment~~
44 ~~will occur unless requested by Member.~~

45
46 4.3. In the absence of Member choice, CalOptima Health shall maintain the Member's relationship
47 with the current PCP and the Health Network selected by the PCP.

48
49 5.4. The effective date of the change shall be the first (1st) of the month following the date of the
50 PCP termination.

51
52 C. If a Member selects a participating PCP that is not accepting new Members, CalOptima Health
53 shall:

5. If the Provider is contracted with CalOptima Health to continue seeing Members with certain diagnosis as described in Section II.O.1. of this policy, no change in Member's PCP assignment will occur unless requested by Member.

~~1.a. Inform the Member to choose another participating PCP.~~

E. ~~2. Contact the PCP, if~~ Medi-Cal: If a Member contacts Health Network Eligible Member moves outside of Orange County, the Member's Health Network or CHCN shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima Health and indicates an existing relationship with a participating PCP not accepting new Members, and make all reasonable efforts to ensure program.

1. Upon notice that the a Health Network Eligible Member may continue an existing relationship has moved outside of Orange County, Health Network shall attempt to verify this information with the participating PCP. Member. The Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.

2. A Health Network provider shall notify CalOptima Health of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Health Customer Service Department.

3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima Health shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.

F. Medi-Cal: CalOptima Health recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in their family in accordance with Section II.D. of this policy. A Family Linked Member may contact CalOptima Health's Customer Service Department to request enrollment in different Health Network from other Members of their family.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Community Network (CHCN) Primary Care Provider (PCP) Selection Form and Guide

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

~~B.~~ CalOptima Health Contract for Policy AA.1207a: CalOptima Health Auto-Assignment

C. CalOptima Health Policy CC.1500: Continuity of Care Services for Members Transitioning into CalOptima Health

D. CalOptima Health Policy CC.1501: Continuity of Care During Health Network or Provider Termination

~~D.E.~~ CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct

~~E.F.~~ CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services

G. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program

H. CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination

I. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services

~~F.J.~~ CalOptima Health Policy GA.3201: Document Management Program

~~G.~~ CalOptima Health Policy GG.1600: Access and Availability Standards

~~H.K.~~ CalOptima Health Policy HH.3023: Information Sharing

L. Covered California PCP Assignment Letter

~~I.M.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition

~~J.N.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)

~~K.O.~~ Medi-Cal Health Network/PCP Assignment Letter

~~L.P.~~ Title 22, California Code of Regulations (CCR), §55170

~~M.~~ Title 42, Code of Federal Regulations (CFR), §438.10(f)(2)

~~N.Q.~~ Welfare and Institutions Code (WIC), §§ 14087.325 and 14094.14

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/07/2015	Department of Health Care Services (DHCS)	Approved as Submitted
10/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/17/2018	Department of Health Care Services (DHCS)	Approved as Submitted
06/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted
<u>09/09/2026</u>	<u>Department of Health Care Services (DHCS)</u>	<u>File and Use</u>

VII. BOARD ACTION(S)

Date	Meeting
11/05/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors
05/07/2026	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	07/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	01/01/2013	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2015	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2016	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2017	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/06/2018	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2019	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2020	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	10/01/2021	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2022	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	05/01/2023	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	04/01/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	12/05/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2025	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	07/01/2026	DD.2006b	Member Primary Care Provider Selection /Assignment	Medi-Cal
<u>Revised</u>		<u>DD.2006b</u>	<u>Member Primary Care Provider and Health Network Selection/Assignment</u>	<u>Covered California Medi-Cal</u>

1 IX. GLOSSARY
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Term	Definition
Adult Expansion Population	Medi-Cal: An expansion population as defined by amended Welfare and Institutions Code (W&I) Section 14007.8 for full scope Medi-Cal to individuals who are twenty-six (26) through forty-nine (49) years of age, and who do not have satisfactory immigration status (SIS) as required by W&I Section 14011.2.
Authorized Representative	Covered California: 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 DHCS State Fair Hearings, 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. Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
California Children's Services (CCS)-Eligible Condition	Medi-Cal: A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	Medi-Cal: A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	Medi-Cal: A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
CalOptima Health Direct (COHD) Member	Medi-Cal: A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria:

Term	Definition
	1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, this Contract, and APLs that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community Based Services (HCBS) program as specified in Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under this Contract, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than 21 years of age. Contractor is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's

Term	Definition
	Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State-Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with APL 22-012. <u>Covered California: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law.</u> 17. <u>Medi-Cal: Medi-Cal services for which [MCP]CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form)</u>
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Member	<u>Medi-Cal:</u> For the purposes of this policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal, or the United States Social Security Administration, who is enrolled in the CalOptima Health program and the CalOptima Health Community Network.

Term	Definition
	<u>Covered California:</u> 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.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
<u>Premium</u>	<u>Covered California:</u> A monthly fee that is paid by or on behalf of a Member by Subscriber to CalOptima Health for health coverage after Advanced Premium Tax Credits are applied, to effectuate and maintain coverage. Premiums are in addition to any Copayment, Coinsurance, or Deductible.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Provider	<u>Covered California:</u> A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal:</u> Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Seniors and Persons with Disabilities (SPD)	<u>Medi-Cal:</u> Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.



Policy: DD.2006b
Title: **Member Primary Care Provider and Health Network Selection/Assignment**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2011

Revised Date:

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

I. PURPOSE

This policy describes the criteria by which a CalOptima Health Member shall select or be assigned a Health Network and Primary Care Provider (PCP).

II. POLICY

- A. CalOptima Health is committed to a Health Network Eligible Member's right to choose a Health Network. CalOptima Health also recognizes that it is in the best interest of a Member to establish a medical home and maintain continuity of care with a PCP and Health Network.
- B. As part of CalOptima Health's commitment to these objectives, CalOptima Health shall assign the Member to a participating PCP and Health Network in accordance with this policy.
1. Unless otherwise specified by this policy, Health Network Eligible Members may select or be assigned to any participating PCP and Health Network currently accepting new Members.
 2. **Covered California:** Members will be assigned to a PCP and Health Network upon receipt of the binder premium payment (Effectuation) by CalOptima Health.
 3. American Indian Members may choose an American Indian Health Care Provider within CalOptima Health's provider network as their Primary Care Provider.
 4. **Medi-Cal:** Members less than twenty-one (21) years of age may select Children's Hospital of Orange County (CHOC) Health Alliance as their Health Network.
 5. **Medi-Cal:** A Member who is known to be participating in California's Children's Services (CCS) may only enroll in a Health Network that is participating in the Whole-Child Model program.
- C. A Health Network Eligible Member shall be subject to the Auto-Assignment process no later than the Member's effective date of coverage with CalOptima Health, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

1. Members with a Medicare Advantage Plan or have Medicare Part B are not subject to auto-assignment and will be assigned to COD.
- D. **Medi-Cal:** CalOptima Health recognizes that Family Linked Members may be best served by a single Health Network to ensure coordinated delivery of services by a Provider who is knowledgeable about the diverse needs of all the Members in the family. To facilitate this objective, CalOptima Health shall assign a Family Linked Member whose family includes a Member already enrolled in a Health Network to that Health Network in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.
1. CalOptima Health shall assign a Family Linked Member to the same PCP and Health Network their youngest sibling if such Family Linked Member is under the age of twenty-one (21) years.
 2. If a Family Linked Member is over the age of twenty-one (21) years and their youngest sibling is enrolled in CHOC Health Alliance, CalOptima Health shall assign the Family Linked Member to the Health Network of another family Member, if applicable.
 3. If the Member is known to be eligible with the Whole-Child Model program/California Children's Services Program (CCS) and the Member's youngest sibling is assigned to a PCP and Health Network that does not participate in the WCM/CCS program, the Family Link process will not apply.
- E. CalOptima Health shall only assign a Member to a participating PCP who has been credentialed as a PCP by CalOptima Health or a Health Network.
- F. A Member shall have the right to select a participating Community Health Center or Non-Physician Medical Practitioner as their PCP. If a Member chooses a participating Non-Physician Medical Practitioner as their PCP, the Member shall be assigned directly to the supervising physician and not the Non-Physician Medical Practitioner.
- G. **Medi-Cal:** A Member categorized as a Senior or Person with a Disability (SPD) shall have the right to choose a PCP specialist physician who is a participating Provider, is willing to perform the role of the PCP, and has met CalOptima Health's requirements for a specialist to act as a PCP.
- H. **Medi-Cal:** A Member eligible for the California Children's Services (CCS) Program, or the Member's parent(s), custodial parent(s), legal guardian(s), or other Authorized Representative(s), shall have the right to request a specialist as a PCP if the specialist agrees to serve in a PCP role and is a CCS-paneled Provider qualified to treat the required range of CCS-Eligible Conditions of the CCS child or youth, in accordance with CCS program rules and regulations.
- I. **Medi-Cal:** CalOptima Health shall maintain the existing PCP assignment process for the Adult Expansion Population by designating a point of contact to coordinate with county uninsured programs and public health care systems to share data and use that data to effectuate PCP assignments.
1. CalOptima Health shall identify unique individuals in the county uninsured programs or public health care systems by Client Index Number (CIN). If the CIN is not available, other data elements shall be used such as name, date of birth, and address.
 2. CalOptima Health shall send the Member PCP Assignment file with all the data elements outlined in the data transmission requirements, outlined in DHCS APL 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition, to the county uninsured programs and public health care systems.

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3. CalOptima Health shall receive data for the Adult Expansion Population from county uninsured programs and public health care systems to match PCP assignments for new and transitioning Members. CalOptima Health shall use the data elements provided to complete a Member match and PCP assignment.
 4. CalOptima Health shall return the PCP Assignment Return File to the county uninsured programs and/or public health systems of the Members successfully assigned a PCP match.
 5. CalOptima Health shall not preclude assignment based on a PCP having a closed panel or not accepting new Members.
 6. CalOptima Health shall receive, store, use, or transmit PHI and share data, in accordance with CalOptima Health Policy HH.3023: Information Sharing.
 7. CalOptima Health shall securely destroy data for individuals who do not ultimately enroll into CalOptima Health, in accordance with CalOptima Health Policy GA.3201: Document Management Program and with Health Insurance Portability and Accountability Act (HIPAA) regulations.
- J. CalOptima Health shall make reasonable efforts to ensure that a Member expressing a desire to continue their existing relationship with a participating PCP is assigned to such PCP.
- K. A Member who selects or is assigned to a participating Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as their PCP:
1. Shall be assigned directly to the FQHC or RHC; and
 2. Shall not be assigned to an individual PCP performing services on behalf of the FQHC or RHC.
- L. CalOptima Health shall disclose to a Member the reason for which he or she could not select or be assigned to a specific PCP.
- M. A Member may request a change to their participating PCP and/or health network at any time in accordance with this policy.
- N. **Medi-Cal:** CalOptima Health shall notify the CalOptima Health Community Network (CHCN) PCP via the provider portal that they have been selected by a Member, or that they have been assigned a Member by CalOptima Health, within ten (10) calendar days after completion of the selection or assignment.
- O. CalOptima Health shall notify the Health Networks of a PCP and/or health network assignment via the daily and monthly eligibility file.
- P. **Medi-Cal:** If a participating PCP terminates the contractual relationship with CHCN, CalOptima Health shall assign impacted Members to a new PCP of the Member's choice. In the absence of Member choice, if the PCP requests to maintain the relationship with the Member, the Member shall be assigned to a Health Network of the PCP's choice.
1. Members diagnosed with the following conditions shall remain with CHCN and may continue with their current PCP if the PCP is contracted to see Members with the conditions outlined below. If the PCP is not contracted with CalOptima Health, the Member shall be assigned to a new PCP of the Member's choice or auto assigned in the absence of Member choice:

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- a. Diagnosed with hemophilia;
 - b. A Member with a Breast and Cervical Cancer Treatment Program (BCCTP) Primary Aid Code;
 - c. Listed for a Major Organ Transplant or approved for a Bone Marrow Transplant (BMT);
 - d. Has received a Major Organ Transplant or BMT within one hundred twenty (120) calendar days prior to the Member's effective date of enrollment in CalOptima Health; or
 - e. Is diagnosed with End Stage Renal Disease (ESRD).
- Q. CalOptima Health or Health Networks shall be responsible for providing Covered Services to its Members, in accordance with its contract and applicable statutes, regulations, CalOptima Health policies, and other requirements of the CalOptima Health program.
- 1. If a Health Network Eligible Member moves outside of Orange County, the assigned Health Network shall remain responsible for all Covered Services until the Member is no longer enrolled in the CalOptima Health program.
 - 2. **Medi-Cal:** If a Health Network Eligible Member becomes the responsibility of the Public Administrator/Public Guardian or is in an Institute for Mental Disease and is placed outside of Orange County, the assigned Health Network shall continue to be responsible for all Covered Services until the Health Network or the Public Administrator/Public Guardian submits a request to change the Member in CalOptima Health Direct, in accordance with CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
 - 3. **Medi-Cal:** If Member becomes the responsibility of the Foster Care Program, the assigned Health Network shall remain responsible for all Covered Services. The Member's foster parent, legal guardian, or the Orange County Children & Family Services Department may request to transition the Member into CalOptima Health Direct (COHD) – Administrative (COHD-A), in accordance with CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct.
- R. CalOptima Health or Health Networks shall ensure Continuity of Care for Members who transition into CalOptima Health in accordance with CalOptima Health Policies CC.1500: Continuity of Care for Members Transitioning into CalOptima Health and GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.
- S. In the event that a Member is required to change Health Networks, due to Health Network termination, CalOptima Health and the receiving Health Network shall collaborate to coordinate the provision of Covered Services for the affected Member, in accordance with CalOptima Health Policies CC.1501: Continuity of Care During Health Network or Provider Termination and GG.1304: Continuity of Care During Health Network or Provider Termination.
- T. CalOptima Health shall provide written notice of termination of a contracted PCP and/or Health Network to each Member in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.

III. PROCEDURE

- A. PCP and Health Network Selection or Assignment for a Newly Enrolled Member

1. Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS) or Covered California, CalOptima Health shall ensure that a Member is assigned to a PCP and Health Network no later than the Member's effective date of coverage with CalOptima Health.
2. **Medi-Cal:** CalOptima Health shall create/update the Member's profile status in Facets and assign the Member to a participating PCP and Health Network in accordance with CalOptima Health policy AA.1207a: CalOptima Health Auto Assignment.
 - a. If an Adult Expansion Population Member's PCP data is received from the county uninsured programs and public health care systems, CalOptima Health shall assign the Member to the PCP listed in the PCP Assignment File.
3. **Covered California:** CalOptima Health shall create/update the member's profile status in Facets to "pending" until the binder payment is received by CalOptima Health. Once binder payment is received and Member has been effectuated, the Member shall be assigned to a participating PCP and Health Network in accordance with CalOptima Health policy AA.1207a: CalOptima Health Auto Assignment:
4. CalOptima Health shall notify a Member, in writing of the Member's Health Network and PCP assignment within ten (10) calendar days after completion of the assignment, with instructions on how the Member may request to change their participating PCP and/or Health Network.
5. A Member may request to change their PCP and/or Health Network change at any time by:
 - a. **Medi-Cal:** Completing a PCP/Health Network Selection Form;
 - i. Only a Health Network Eligible Member or the Member's Authorized Representative shall sign a Health Network Selection Form on behalf of the Member. If a Health Network Selection Form is not signed, CalOptima Health staff shall contact the Member or the Member's Authorized Representative and attain a verbal attestation.
 - ii. If CalOptima Health receives a Health Network Eligible Member's completed Health Network Selection Form by the tenth (10th) calendar day of a month, the Member shall be enrolled into the selected Health Network no later than the first (1st) calendar day of the immediately following month. If CalOptima Health receives a Member's completed Health Network Selection Form after the tenth (10th) calendar day of the month, the Member shall be enrolled into the selected Health Network no later than the first (1st) calendar day of the month after the immediately following month.
 - b. Contacting CalOptima Health's Customer Service Department or
 - c. Submit request via CalOptima Health's secure Member portal.
6. **Medi-Cal:** The PCP and/or Health Network change will be effective on the 16th of the month if the request is received by the 15th of the month or the 1st of the following month if the request is received after the 15th of the month.
7. **Covered California:** The PCP and/or Health Network change will be effective on the 1st of the following month from the date of the request.

8. Members or their authorized representative may request an earlier effective date if they were auto-assigned but prefer to continue with a provider with whom they have an established relationship.
9. If a Member or authorized representative requests an earlier effective date for other reasons, Customer Service staff shall:
 - a. Forward the request to Provider Network/Health Network Provider Relations who will submit it to the Health Network for review.
 - b. If the request is approved by the Health Network, the change will be processed with the effective date specified in the request.
 - c. If the Health Network denies the request, Customer Service will notify the member or authorized representative and provide assistance with selecting and alternative another PCP and/or Health Network.
10. If a Member selects a participating PCP that has a closed panel or is not accepting new Members, CalOptima Health shall:
 - a. Inform the Member to choose another participating PCP.
 - b. If a Member expresses that they have an established relationship with a participating Primary Care Provider (PCP), before proceeding with the change request, CalOptima Health shall confirm the panel closure is not related to quality issues and contact the PCP to confirm the acceptance.
 - c. If a PCP or Health Network submits an acceptance letter requesting a Member assignment to a closed their panel and attesting that the Member is in agreement with the change, CalOptima Health shall assign the Member to the PCP effective the first (1st) of the following month.

B. Medi-Cal: Members eligible for enrollment in CHOC Health Alliance

1. Subject to other limitations set forth in this policy, a Member who meets criteria set forth in Section II.B.4. of this policy may select CHOC Health Alliance.
2. CalOptima Health shall assign a new Health Network Eligible Member to CHOC Health Alliance, in accordance with Section III.A.2. of this policy.
3. A Member who is enrolled in CHOC Health Alliance shall select another Health Network prior to his or her twenty-first (21st) birthday in accordance with the following:
 - a. CalOptima Health shall provide the Member with a ninety (90), sixty (60) and thirty (30) calendar day written notice to select another Health Network prior to the Member's twenty-first (21st) birthday. The written notices shall inform the Member that CHOC will only provide health care service until the end of the Member's twenty-first (21st) birth month.
 - b. If the Member does not select another Health Network within the designated timeframe, CalOptima Health shall assign the Member to a Health Network as follows:

- 1 i. If the Member's PCP is contracted with another Health Network, CalOptima Health
2 shall assign the Member to a Health Network of the Member's PCP's choice; or
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4 ii. If the Member's PCP is not contracted with another Health Network, CalOptima Health
5 shall assign the Member to a Health Network and PCP based on geographic access.
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7 c. The Member shall be enrolled in CHCN or the new Health Network effective the first (1st)
8 calendar day of the month immediately following the Member's twenty-first (21st)
9 birthday.
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11 4. A Member shall remain in CHOC Health Alliance beyond the Member's twenty-first (21st)
12 birthday if the Member meets all of the following criteria:
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14 a. Diagnosed with one (1) of the following California Children's Services (CCS)-Eligible
15 Conditions:
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17 i. Cystic Fibrosis;
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19 ii. A rare metabolic disorder not including Phenylketonuria (PKU);
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21 iii. Spina Bifida; or
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23 iv. Muscular Dystrophy.
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25 b. Eligible to receive services from CCS for the CCS-Eligible Condition as of the day before
26 the Member's twenty-first (21st) birthday; and
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28 c. Receiving care for the CCS-Eligible Condition from a pediatric specialist who is contracted
29 with CHOC Health Alliance as of the day before the Member's twenty-first (21st) birthday.
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- 31 5. A Member who remains in CHOC Health Alliance pursuant to Section III.B.4.a of this policy
32 shall remain in CHOC Health Alliance until:
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34 a. The Member selects CHCN or another Health Network; or
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36 b. The Member's pediatric specialist determines that the Member's care may safely be
37 transitioned to CHCN or another Health Network.
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- 39 C. If a PCP terminates participation with a Health Network, or if a Health Network terminates its
40 contract with CalOptima Health, CalOptima Health shall provide written notification to affected
41 Members at least thirty (30) calendar days prior to the effective date of the contract termination. in
42 accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or
43 Availability of Providers or Covered Services.
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- 45 D. **Medi-Cal:** If a PCP terminates with CHCN, and contracted with other Health Networks, and
46 requests to maintain the relationship with the Member;
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48 1. The PCP shall submit a written request to CalOptima Health's Provider Relations Department at
49 least ninety (90) calendar days prior to the expected date of termination. The written request
50 must state the PCP's intention to continue the relationship with the Members and specify the
51 name of the Health Network for which the PCP is seeking assignment.
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2. CalOptima Health shall provide written notification to the Member thirty (30) calendar days prior to the effective date of the contract termination in accordance with CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services.
 3. In the absence of Member choice, CalOptima Health shall maintain the Member's relationship with the current PCP and the Health Network selected by the PCP.
 4. The effective date of the change shall be the first (1st) of the month following the date of the PCP termination.
 5. If the Provider is contracted with CalOptima Health to continue seeing Members with certain diagnosis as described in Section II.O.1. of this policy, no change in Member's PCP assignment will occur unless requested by Member.
- E. **Medi-Cal:** If a Health Network Eligible Member moves outside of Orange County, the Member's Health Network or CHCN shall continue to be responsible for Covered Services until the Member is no longer enrolled in the CalOptima Health program.
1. Upon notice that a Health Network Eligible Member has moved outside of Orange County, Health Network shall attempt to verify this information with the Member. The Health Network shall instruct the Member to contact the County of Orange Social Services Agency or the United States Social Security Administration to report a change of address.
 2. A Health Network provider shall notify CalOptima Health of a Health Network Eligible Member's change of address by submitting a Medi-Cal Contact Information Request Form (MC 354) to the CalOptima Health Customer Service Department.
 3. Upon notice that a Health Network Eligible Member has moved out of Orange County, CalOptima Health shall send the Member's new residence information to the County of Orange Social Services Agency, in accordance with Title 22 of the California Code of Regulations, Section 50188, or to the U.S. Social Security Administration.
- F. **Medi-Cal:** CalOptima Health recognizes that a situation may occur in which the needs of a Family Linked Member may not be best served by enrollment in the same Health Network as other Members in their family in accordance with Section II.D. of this policy. A Family Linked Member may contact CalOptima Health's Customer Service Department to request enrollment in different Health Network from other Members of their family.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
- C. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima Health
- D. CalOptima Health Policy CC.1501: Continuity of Care During Health Network or Provider Termination
- E. CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct

- F. CalOptima Health Policy DD.2012: Member Notification of Change in Location or Availability of Providers or Covered Services
- G. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program
- H. CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination
- I. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
- J. CalOptima Health Policy GA.3201: Document Management Program
- K. CalOptima Health Policy HH.3023: Information Sharing
- L. Covered California PCP Assignment Letter
- M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition
- N. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
- O. Medi-Cal PCP Assignment Letter
- P. Title 22, California Code of Regulations (CCR), §55170
- Q. Welfare and Institutions Code (WIC), §§ 14087.325 and 14094.14

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2010	Department of Health Care Services (DHCS)	Approved as Submitted
04/07/2015	Department of Health Care Services (DHCS)	Approved as Submitted
10/09/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/17/2018	Department of Health Care Services (DHCS)	Approved as Submitted
06/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted
09/09/2026	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
11/05/2009	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2024	Regular Meeting of the CalOptima Health Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors
05/07/2026	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	07/01/2011	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2013	DD.2006b	CalOptima Care Network Member Primary Care Provider Selection/Assignment	Medi-Cal
Revised	03/01/2015	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2016	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2017	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/06/2018	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2019	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2020	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	10/01/2021	DD.2006b	CalOptima Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	09/01/2022	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	05/01/2023	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	04/01/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	12/05/2024	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	08/01/2025	DD.2006b	CalOptima Health Community Network Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised	07/01/2026	DD.2006b	Member Primary Care Provider Selection /Assignment	Medi-Cal
Revised		DD.2006b	Member Primary Care Provider and Health Network Selection/Assignment	Covered California Medi-Cal

1 IX. GLOSSARY
2

Term	Definition
Adult Expansion Population	Medi-Cal: An expansion population as defined by amended Welfare and Institutions Code (W&I) Section 14007.8 for full scope Medi-Cal to individuals who are twenty-six (26) through forty-nine (49) years of age, and who do not have satisfactory immigration status (SIS) as required by W&I Section 14011.2.
Authorized Representative	Covered California: 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 DHCS State Fair Hearings, 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. Medi-Cal: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
California Children's Services (CCS)-Eligible Condition	Medi-Cal: A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	Medi-Cal: A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	Medi-Cal: A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Member.
CalOptima Health Direct (COHD) Member	Medi-Cal: A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria:

Term	Definition
	1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Covered Services	Covered California: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law. Medi-Cal: Medi-Cal services for which [MCP]CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form)
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(1)(2)(B)).
Member	Medi-Cal: For the purposes of this policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal, or the United States Social Security Administration, who is enrolled in the CalOptima Health program and the CalOptima Health Community Network. Covered California: 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.
Non-Physician Medical Practitioner	A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.
Premium	Covered California: A monthly fee that is paid by or on behalf of a Member by Subscriber to CalOptima Health for health coverage after Advanced Premium Tax Credits are applied, to effectuate and maintain coverage. Premiums are in addition to any Copayment, Coinsurance, or Deductible.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Provider	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.

Term	Definition
	<u>Medi-Cal:</u> Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Seniors and Persons with Disabilities (SPD)	Medi-Cal: Medi-Cal beneficiaries who fall under specific Aged and Disabled Aid Codes as defined by the DHCS.

1

For 20261001 BOD Review Only



Policy: DD.2005
Title: **Member Informing Materials Requirements**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 09/01/2002

Revised Date:

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

I. PURPOSE

This policy defines the distribution requirements for the CalOptima ~~Health Provider Directory and Formulary, as well as the content and~~ Health's distribution requirements for the CalOptima Health Member informing materials including the Member Handbook, Provider Directory, Formulary and the Health Networks' Member Welcome Letter packet.

II. POLICY

A. CalOptima Health shall produce and distribute a CalOptima Health Provider Directory, Formulary, and Member Handbook, in accordance with this Policy.

B. A Health Network ~~shall~~ may produce and distribute a Member Welcome Letter, in accordance with this policy.

C. CalOptima Health shall provide all Members with the Member Notice annually in lieu of a paper Provider Directory, Pharmacy Formulary, and Member Handbook.

D. CalOptima Health shall provide all Members with a Summary of Benefits.

~~C.E.~~ The CalOptima Health Member Handbook/Evidence of Coverage shall include the following, as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC):

1. CalOptima Health's name, address, toll-free telephone number, and Service Area;

2. Covered Services provided by CalOptima Health, including the amount, duration and scope of Covered Services;

3. Explanation of the appropriate use of health care services in a managed care system;

4. Description of the Member Identification (ID) card and an explanation of its uses;

5. Hours of operations, including twenty-four (24) hour nurse advice telephone numbers;
6. Information on Pediatric Preventive Services (PPS) and Child Health Disability Prevention Services (CHDP), in accordance with CalOptima Health Policy GG.1116: Pediatric Preventive Services;
7. Information on Family Planning Services;
8. Information on Member Advisory Committees;
9. Information on timely access to care;
10. Circumstances in which a Member may have to pay for services;
11. Member Complaint, Appeal, and Grievance procedures, in accordance with CalOptima Health Policies CC.1200: Member Appeals, CC.1201: Member Grievance, HH.1102: Member Grievance and GG.1510: Member Appeal Process;
12. Information on not requiring a referral when members seek an initial mental health assessment;
13. Information on direct access to a women's health specialist;
14. Information on interpreter services provided at no charge, including services for the hearing or speech impaired, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services;
15. A list of all health education opportunities available to Members which includes all CalOptima Health mandated topics;
16. Availability of services and procedures for obtaining care at Federally Qualified Health Centers (FQHCs), Indian Health Services facilities, and from a certified nurse midwife, licensed midwife, and certified nurse practitioner;
17. Rights of a Member who is an American Indian to receive services through Indian Health Services;
18. Information on organ and tissue donation;
19. Information on CalOptima Health's use of Provider financial incentives;
20. Information on second opinions;
21. Member rights and responsibilities, in accordance with CalOptima Health Policy DD.2001: Member Rights and Responsibilities;
22. Information on emergency, non-emergency, and non-medical transportation services, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency and Non-Medical;
23. The causes for which a Member may be disenrolled from the CalOptima Health program;
24. The toll-free telephone number for CalOptima Health Customer Service;

25. Information on all approved Alternative Access Standards (AAS) including:

- a. The Member's right to access in-person service when an AAS is approved;
- b. The process to request assistance in obtaining appointments with Core Specialists within time and distance and timely access standards; and
- c. Available transportation service to a network or out-of-network providers within or outside of timely access standards.

26. Information on how to report suspected Fraud or Abuse; and

27. Other information as required by DHCS and DMHC.

~~3-28.~~ Member procedures for:

- a. Obtaining Covered Services through CalOptima Health's contracted Providers ~~(unless otherwise allowed);~~ including Primary Care Provider appointments and referrals/prior authorization to specialist care providers;
 - i. ~~Through Primary Care Provider (PCP) appointments; and~~
 - ii. ~~The process of obtaining a referral to a Specialty Care Provider or Prior Authorization for services.~~
- b. Selecting or changing a PCP and/or Health Network;
- c. Requesting Medical Record transfer when changing PCPs;
- d. ~~Selecting or changing a Health Network;~~
- e. ~~d.~~ Obtaining Emergency Services within and outside Orange County;
- f. ~~e.~~ Receiving a seventy-two (72)-hour supply of medically necessary medication in an emergency situation;
- g. ~~f.~~ Obtaining Urgent Care Services; and
- h. ~~g.~~ **Medi-Cal:** Scheduling an Initial Health Assessment (IHA) appointment within one hundred twenty (120) calendar days after enrolling in the CalOptima Health program, in accordance with CalOptima Health Policy GG.1613: Initial Health Appointment.

~~4.1. Explanation of the appropriate use of health care services in a managed care system;~~

~~5.1. Description of the Member Identification (ID) card and an explanation of its uses;~~

~~6. Hours of service, including twenty-four (24) hour telephone numbers;~~

~~7.1. Information on Pediatric Preventive Services (PPS) and Child Health Disability Prevention Services (CHDP), in accordance with CalOptima Health Policy GG.1116: Pediatric Preventive Services;~~

~~8.1. Information on Family Planning Services;~~

~~9.29.~~ **Medi-Cal:** Information on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible Members under the age of twenty-one (21).

- a. Update Member-Facing materials as needed with Medi-Cal for Kids & Teens.
- b. Publish the DHCS materials and “Medi-Cal for Kids & Teens: Your Medi-Cal Rights” letter on CalOptima Health’s website.
- c. Mail outreach and education materials consisting of age-appropriate material and “Medi-Cal for Kids & Teens: Your Medi-Cal Rights” letter to new Members under the age of twenty-one (21).
 - i. Materials shall be mailed within seven (7) calendar days of enrollment into CalOptima Health.
- d. On an annual basis by January 1 of each calendar year, CalOptima Health shall mail or share electronically DHCS supplied materials for existing Members under the age of twenty-one (21).

~~10.1. Information on Member Advisory Committees;~~

~~11.1. Information on timely access to care;~~

~~12.30.~~ **Medi-Cal:** Information on CalOptima Health’s Member Liaison Program;

~~13.1. Circumstances in which a Member may have to pay for services;~~

~~14. Member Complaint, Appeal, and Grievance procedures, in accordance with CalOptima Health Policies HH.1102: Member Grievance and GG.1510: Member Appeal Process;~~

~~15.31.~~ **Medi-Cal:** Information on how to access State resources for investigation and resolution of Complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and telephone number;

~~16.32.~~ **Medi-Cal:** State hearing procedures and addresses, in accordance with CalOptima Health Policy HH.1108: State Hearings Process and Procedures;

~~17.1. Information on emergency, non-emergency, and non-medical transportation services, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency and Non-Medical;~~

~~18.33.~~ **Medi-Cal:** Information on Advance Directives;

~~19.1. Member rights and responsibilities, in accordance with CalOptima Health Policy DD.2001: Member Rights and Responsibilities;~~

~~20.34.~~ **Medi-Cal:** Information on how to obtain Minor Consent Services and an explanation of such services;

~~21.35.~~ **Medi-Cal:** Information on Sensitive Services;

~~22.1. Information on not requiring a referral when members seek an initial mental health assessment;~~

~~23.1. Information on direct access to a women's health specialist;~~

~~24.1. Information on interpreter services provided at no charge, including services for the hearing or speech impaired, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services;~~

~~25.1. A list of all health education opportunities available to Members which includes all CalOptima Health mandated topics;~~

~~26.36. Medi-Cal:~~ Availability of services through the Whole-Child Model (WCM) program from Providers outside CalOptima Health's Provider network and how to access these services;

~~27.1. Availability of services and procedures for obtaining care at Federally Qualified Health Centers (FQHCs), Indian Health Services facilities, and from a certified nurse midwife, licensed midwife, and certified nurse practitioner;~~

~~28.1. Rights of a Member who is an American Indian to receive services through Indian Health Services;~~

~~29.37. Medi-Cal:~~ Information on how to obtain Medi-Cal benefits that are not covered by the CalOptima Health program and an explanation of the fee-for-service system;

~~30.38. Medi-Cal:~~ Information on transitional Medi-Cal and how a Member may apply for transitional Medi-Cal;

~~31.39. Medi-Cal:~~ Information on moral objections;

~~32.1. Information on organ and tissue donation;~~

~~33.1. Information on CalOptima Health's use of Provider financial incentives;~~

~~34. Information on CalOptima Health's Drug Formulary;~~

~~35.1. Information on second opinions;~~

~~36.1. The causes for which a Member may be disenrolled from the CalOptima Health program;~~

~~37.1. The toll free telephone number for CalOptima Health Customer Service;~~

~~38.40. Medi-Cal:~~ Information on a Member's right to access an out-of-network provider when there is an Annual Network Certification (ANC) Corrective Action Plan (CAP);

~~39.41. Medi-Cal:~~ Information on the process for a Member to request out-of-network access due to ANC CAP;

~~40. Information on all approved Alternative Access Standards (AAS) including;~~

~~a. The Member's right to access in-person service when an AAS is approved;~~

~~b.a. The process to request assistance in obtaining appointments with Core Specialists within time and distance and timely access standards; and~~

~~c.a. Available transportation service to a network or out-of-network providers within or outside of timely access standards.~~

41.42. **Medi-Cal:** Information on a Member's right to access services that are usually provided by a Mandatory Provider either in or out of the Service Area, including transportation, if no Mandatory Provider types are available in the Service Area.

~~42.1. Information on how to report suspected Fraud or Abuse; and~~

~~43. Other information as required by DHCS.~~

D. CalOptima Health shall make the Member Handbook available in Threshold Languages and alternative formats, including larger print twenty (20) point size font, audio format, or Braille, upon request, standing request, or as needed, at no cost.

~~1. The Member Handbook shall include a notice of non-discrimination, taglines explaining the availability of written translation or oral interpretation to understand the information provided, and the telephone numbers to contact for assistance with the Member Handbook, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.~~

43. Covered California: Information on how to access the DMHC helpline for resolution of Complaints, including website and phone number;

44. Covered California: Information on CalOptima Health's Drug Formulary;

45. Covered California: Information on pharmacy benefits and network;

46. Covered California: Information on Enrollment & Eligibility;

47. Covered California: Information on payment responsibilities;

48. Covered California: Information on disenrollment and cancellations;

~~E.F. Medi-Cal:~~ CalOptima Health shall produce and distribute a Member Notice informing Non-Seniors and Persons with Disabilities (SPD) and Dual Eligible Members how to access the Provider Directory, Member Handbook, and Formulary electronically and how to request a paper copy.

~~E.G. Medi-Cal:~~ CalOptima Health shall send, as part of the welcome packet, a paper form of the Provider Directory to all SPD Members and a Member Notice informing Members how to access the Member Handbook and Formulary electronically and how to request a paper copy.

Medi-Cal:

~~G.A. CalOptima Health shall provide all Members with the Member Notice annually in lieu of a paper Provider Directory, Pharmacy Formulary, and Member Handbook.~~

~~H.A. CalOptima Health shall provide all Members with a Summary of Benefits.~~

H.H. CalOptima Health shall submit the CalOptima Health Member Handbook and Member Notice to DHCS for review and approval, in accordance with this policy.

I. Covered California: Health shall submit the CalOptima Health Member Handbook and Member Notice to DMHC for review and approval, in accordance with this policy.

J. A Member welcome packet shall include information on each of the topics listed below:

1. Member ID card with Welcome Letter.
2. Medi-Cal: A Health Network selection form guide that includes the name, address, and telephone number of all available Health Networks;
3. How to select ~~a PCP~~ or ~~request a PCP~~ change a PCP and Health Network :
 - a. Procedures for selecting or requesting a PCP and/or Health Network change;
 - b. Requirements for PCP and/or Health Network change;
 - c. Reasons a request for PCP and/or Health Network change may be denied;
 - d. Reasons why a Provider may request a change; and
 - e. Procedures for requesting transfer of Medical Records when changing PCPs.
4. Procedures for obtaining Urgent Care and Emergency Services within the Health Network's Service Area and outside of the Health Network's Service Area.
5. Other Items:
 - a. Medi-Cal: The purpose and value of scheduling an IHA within one hundred twenty (120) calendar days after enrollment;
 - b. An insert to inform Members on how to access the Member Handbook/Provider Directory online and how to request a hard copy; and
 - c. CalOptima Health's Customer Service toll-free telephone number.
6. Other information as required by CalOptima Health.

K. A Health Network ~~shall~~may submit the Member Welcome Letter to CalOptima Health for review and approval prior to distribution to Members in accordance with Section III.~~BD~~ of this Policy.

III. PROCEDURE

A. Medi-Cal: Upon receipt of the Member's eligibility information from the Department of Health Care Services (DHCS), CalOptima Health shall send a welcome packet. The welcome packet shall include, but not be limited to, the following information:

1. New Member Welcome Letter/CalOptima Health Medi-Cal Identification Card;
2. Health Network Selection Form Guide;

1 3. Health Network Selection Form;

2
3 4. Summary of Benefits;

4
5 5. New Member Orientation RSVP Form;

6
7 6. Instructions on how to access the Provider Directory and Member Handbook;

8
9 7. Initial Health Appointment Form;

10
11 8. Notice of Non-discrimination and Language Assistance Taglines; and

12
13 9. Postage-paid envelope

14
15 **B. Covered California:** Upon receipt of the Member's eligibility information from Covered California
16 and Member Effectuation, CalOptima Health shall send a welcome packet. The welcome packet
17 shall include, but not be limited to, the following information:

18
19 1. Welcome Letter

20
21 2. PCP Assignment Notice

22
23 3. ID Card

24
25 4. Summary of Benefits

26
27 5. Pharmacy Benefit Insert

28
29 6. Nurse Advice Line Insert

30
31 7. Electronic Format Insert

32
33 8. Member Rights and Responsibilities Insert

34
35 9. Enrollee Contact Guidelines

36
37 10. Notice of Availability/ Nondiscrimination

38
39 **A.C.** CalOptima Health Provider Directory, Formulary, and Member Handbook

40
41 1. CalOptima Health shall produce the CalOptima Health Provider Directory, Formulary, and
42 Member Handbook at a minimum of twelve (12) point font, with titles and captions at a
43 minimum twelve (12) point bold font, written at no higher than a sixth (6th) grade level, and in
44 all Threshold Languages.

45
46 2. On an annual basis, CalOptima Health shall submit the CalOptima Health Member Medi-Cal
47 Handbook to DHCS and the CalOptima Health Covered Member Handbook to DMHC for
48 review and approval.

49
50 3. **Medi-Cal:** CalOptima Health shall create two (2) distinct welcome packets for SPD and non-
51 SPD Members to ensure SPD Members will continue to receive the paper copy of the Provider
52 Directory.
53

4. **Medi-Cal:** CalOptima Health shall mail the welcome packet no later than seven (7) calendar days after receipt of the Member's eligibility information from the State, in accordance with CalOptima Health Policies DD.2006: Enrollment in/Eligibility with CalOptima Health Direct and DD.~~2008: 2006b: Member Primary Care Provider and~~ Health Network ~~and CalOptima Health Community Network Selection Process/Assignment~~.

5. **Covered California:** CalOptima Health shall mail the welcome packet no later than ten (10) calendar days after Member effectuation, in accordance with CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment

5.6. **Medi-Cal:** CalOptima Health shall send, to non-SPD Members, a Member Notice informing how to view the Provider Directory, Formulary, and Member Handbook on CalOptima Health's website and how the Member can request a paper copy in accordance with DHCS All Plan Letter (APL) 19-003: Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format.

6.7. **Medi-Cal:** CalOptima Health shall continue to send, as part of the welcome packets, a paper form of the Provider Directory to SPD Members and notice informing how to view the Formulary and Member Handbook on CalOptima Health's website and how the Member can request a paper copy in accordance with DHCS APL 19-003: Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format.

7.8. **Medi-Cal:** The Member Notice shall be green in color with the header "Important Plan Information" to be easily identifiable by the Member, a minimum of twelve (12) point font, and written at no higher than a sixth (6th) grade level, and in all Threshold Languages.

8.9. **Medi-Cal:** On an annual basis, CalOptima Health shall inform a Member of the availability of the CalOptima Health Provider Directory, ~~Formulary~~, and Member Handbook.

9.10. CalOptima Health shall provide a Member with the most up-to-date Provider Directory, Formulary and/or Member Handbook within five (5) business days of the Member's request.

B.D. Member Welcome Letter

1. A Health Network ~~shall~~may produce a Member Welcome Letter at a minimum twelve (12) point font, with titles and captions at a minimum twelve (12) point bold font, written at no higher than a sixth (6th) grade level, and in all Threshold Languages.

2. A Health Network shall submit a Member Welcome Letter to CalOptima Health for review and approval prior to distribution to Members.

a. CalOptima Health shall make every effort to complete its review of the Member Welcome Letter within thirty (30) calendar days.

~~b. A Health Network shall not distribute a Member Welcome Letter to Members without CalOptima Health's approval.~~

3. A Health Network shall submit any updates to the Member Welcome Letter to CalOptima Health for review and approval prior to distribution to Members.

4. A Health Network shall send a Member Welcome Letter to a Member or head of household no later than seven (7) calendar days after receipt of notification that such Member has enrolled in the Health Network.

1
2 **C. CalOptima Health Community Network (CHCN) Informing materials**
3

4 1. CalOptima Health shall send the following items to a Member or head of household who selects
5 CHCN as their Health Network, no later than seven (7) calendar days after receipt of
6 notification that such Member selected CHCN:
7

8 a. CHCN Welcome Letter;

9 b. ID Card;

10 ~~c. 1. Summary of Benefits;~~

11 d. Member Handbook insert;

12 e. New Member Orientation Invitation; and

13 f. Initial Health Assessment form.
14

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20 **IV. ATTACHMENT(S)**

21 Not Applicable
22

23
24 **V. REFERENCE(S)**
25

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

27 B. CalOptima Health Contract for Healthcare Services

28 ~~C. CalOptima Health Policy CC.1200: Member Appeals~~

29 ~~D. CalOptima Health Policy CC.1201: Member Grievance~~

30 ~~E. CalOptima Health Policy DD.2001: Member Rights and Responsibilities~~

31 ~~F. CalOptima Health Policy DD.2002: Cultural and Linguistic Services~~

32 ~~G. CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct~~

33 ~~H. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community
34 Network Selection Process~~

35 ~~I. CalOptima Health Policy GG.1116: Pediatric Preventive Services~~

36 ~~J. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency and Non-Medical~~

37 ~~K. CalOptima Health Policy GG.1510: Member Appeal Process~~

38 ~~L. CalOptima Health Policy GG.1613: Initial Health Appointment~~

39 ~~M. CalOptima Health Policy HH.1102: Member Grievance~~

40 ~~N. CalOptima Health Policy HH.1108: State Hearings Process and Procedures~~

41 ~~O. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements
42 for Freestanding Birth Centers and the Provision of Midwife Services (Supersedes APL 16-017)~~

43 ~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-003: Providing
44 Informing Materials to Medi-Cal Beneficiaries in an Electronic Format~~

45 ~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-006: Medi-Cal Managed
46 Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-
47 018)~~

48 P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification
49 Requirements (Supersedes APL 21-006)

50 Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements For
51 Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal
52 Members Under the Age of 21 (Supersedes APL 19-010)

R. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-005: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (Supersedes APL 21-004)

S. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)

S.T. Title 42, Code of Federal Regulations (CFR), §§ 438.10(c), 438.10(d) and 438.10(g)

VI. REGULATORY AGENCY APPROVAL

Date	Regulatory Agency	Response
02/11/2011	Department of Health Care Services (DHCS)	Approved as Submitted
02/25/2011	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2015	Department of Health Care Services (DHCS)	Approved as Submitted
12/24/2019	Department of Health Care Services (DHCS)	Approved as Submitted
10/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
06/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/07/2023	Department of Health Care Services (DHCS)	Approved as Submitted
09/09/2026	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	09/01/2004	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2005	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2008	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2009	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2011	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2013	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	07/01/2015	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	09/01/2016	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	07/01/2017	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	12/01/2017	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	11/01/2018	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	08/01/2019	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	05/01/2020	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	07/01/2021	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	09/01/2022	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	04/01/2023	DD.2005	Member Informing Materials Requirements	Medi-Cal

Action	Date	Policy	Policy Title	Program
Revised	06/01/2023	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	12/01/2024	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	12/01/2025	DD.2005	Member Informing Materials Requirements	Medi-Cal
<u>Revised</u>		<u>DD.2005</u>	<u>Member Informing Materials Requirements</u>	<u>Covered California Medi-Cal</u>

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For 20261001 BOD Review Only

1 IX. GLOSSARY
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Term	Definition
Advanced Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a member is Incapacitate.
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Appeal	<u>Covered California: A type of Grievance related to a Member appeal within CalOptima Health's Grievance system. A type of Grievance related to any of the following medical necessity determination or coverage actions taken by CalOptima Health:</u> <u>1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.</u> <u>2. The reduction, suspension, or termination of a previously authorized service.</u> <u>3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a).</u> <u>4. The failure to provide services in a timely manner.</u> <u>5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals.</u> <u>6. The denial of a Member's request to dispute financial liability.</u> <u>Medi-Cal:</u> A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: - 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; - A reduction, suspension, or termination of a previously authorized service; - A denial, in whole or in part, of payment for a service; - Failure to provide services in a timely manner; or - Failure to act within the timeframes provided in 42 CFR 438.408(b).
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.

Term	Definition
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Core Specialist	Adult and pediatric providers as specified in Department of Health Care Services All Plan Letter 20-003: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.

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Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 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);
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Term	Definition
	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 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. <u>Covered California: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law.</u> <u>Medi-Cal: Medi-Cal services for which [MCP] CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form).</u> 17.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs.
<u>Department of Managed Health Care (DMHC)</u>	<u>Covered California: California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.</u>
Emergency Services	<u>Covered California: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in and Health & Safety Code § 1317.1(a)(1) and §1317(a)(2)(A).</u> <u>Medi-Cal: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).</u>

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(1)(2)(B)).
Formulary	<u>Covered California: A list of outpatient prescription drugs, selected by the Plan(s) and revised periodically, which are available to Members.</u> <u>Medi-Cal: The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Health Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.</u>
Grievance	<u>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 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. An inquiry is not a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, the incident must be considered a Grievance. A Grievant is the individual making or filing the Grievance.</u> <u>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</u>

Term	Definition
	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.
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.
Mandatory Provider	Providers who managed care plans must offer to contract with, where available, and include Federally Qualified Health Centers (FQHCs), Rural Health Centers, Freestanding Birthing Center (FBC), Certified Nurse Manager, Licensed Midwife, and Indian Health Facilities (IHF), as defined in Department of Health Care Services All Plan Letter 23-001: Network Certification Requirements.
Member	<u>A Medi-Cal: For the purposes of this policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program- and the CalOptima Health Community Network.</u> <u>Covered California: 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.</u>
Member Welcome Letter	A letter that is prepared and distributed by the Health Network; contains general information about the Health Network.
Minor Consent Services	Those Covered Services of a sensitive nature that a minor does not need parental consent to access, related to: 1. Sexual Assault, including rape; 2. Drug and alcohol abuse for a minor/child twelve (12) years of age or older; 3. Pregnancy; 4. Family planning; and/or 5. Sexually Transmitted Diseases (STDs) for a minor/child twelve (12) years of age or older; and/or 6. Outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or Child abuse.
Pediatric Preventive Services (PPS)	Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the CHDP Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.
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.

Term	Definition
Prior Authorizations	<u>Covered California: 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).</u> <u>Medi-Cal:</u> A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	<u>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.</u> <u>Medi-Cal:</u> 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.
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Service Area	<u>Covered California: The county or counties in which CalOptima Health is approved to operate under the terms of its QHP Contract with the Exchange. The service area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by the Exchange for CalOptima Health to operate under the terms of the QHP Contract.</u> <u>Medi-Cal:</u> The geographical area that DHCS authorizes CalOptima Health to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima Health is approved to operate in.
Specialty Care Provider	Provider of specialty care given to Members by referral by other than a Primary Care Provider.
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS and DMHC.
Urgent Care Services	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.



Policy: DD.2005
Title: **Member Informing Materials Requirements**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 09/01/2002

Revised Date:

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

I. PURPOSE

This policy defines the distribution requirements for the CalOptima Health's distribution requirements for CalOptima Health Member informing materials including the Member Handbook, Provider Directory, Formulary and Welcome packet.

II. POLICY

- A. CalOptima Health shall produce and distribute a CalOptima Health Provider Directory, Formulary, and Member Handbook, in accordance with this Policy.
- B. A Health Network may produce and distribute a Member Welcome Letter, in accordance with this policy.
- C. CalOptima Health shall provide all Members with the Member Notice annually in lieu of a paper Provider Directory, Pharmacy Formulary, and Member Handbook.
- D. CalOptima Health shall provide all Members with a Summary of Benefits.
- E. The CalOptima Health Member Handbook/Evidence of Coverage shall include the following, as required by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC):
 1. CalOptima Health's name, address, toll-free telephone number, and Service Area;
 2. Covered Services provided by CalOptima Health, including the amount, duration and scope of Covered Services;
 3. Explanation of the appropriate use of health care services in a managed care system;
 4. Description of the Member Identification (ID) card and an explanation of its uses;
 5. Hours of operations, including twenty-four (24) hour nurse advice telephone numbers;

6. Information on Pediatric Preventive Services (PPS) and Child Health Disability Prevention Services (CHDP), in accordance with CalOptima Health Policy GG.1116: Pediatric Preventive Services;
7. Information on Family Planning Services;
8. Information on Member Advisory Committees;
9. Information on timely access to care;
10. Circumstances in which a Member may have to pay for services;
11. Member Complaint, Appeal, and Grievance procedures, in accordance with CalOptima Health Policies CC.1200: Member Appeals, CC.1201: Member Grievance, HH.1102: Member Grievance and GG.1510: Member Appeal Process;
12. Information on not requiring a referral when members seek an initial mental health assessment;
13. Information on direct access to a women's health specialist;
14. Information on interpreter services provided at no charge, including services for the hearing or speech impaired, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services;
15. A list of all health education opportunities available to Members which includes all CalOptima Health mandated topics;
16. Availability of services and procedures for obtaining care at Federally Qualified Health Centers (FQHCs), Indian Health Services facilities, and from a certified nurse midwife, licensed midwife, and certified nurse practitioner;
17. Rights of a Member who is an American Indian to receive services through Indian Health Services;
18. Information on organ and tissue donation;
19. Information on CalOptima Health's use of Provider financial incentives;
20. Information on second opinions;
21. Member rights and responsibilities, in accordance with CalOptima Health Policy DD.2001: Member Rights and Responsibilities;
22. Information on emergency, non-emergency, and non-medical transportation services, in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency and Non-Medical;
23. The causes for which a Member may be disenrolled from the CalOptima Health program;
24. The toll-free telephone number for CalOptima Health Customer Service;
25. Information on all approved Alternative Access Standards (AAS) including:

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- a. The Member's right to access in-person service when an AAS is approved;
 - b. The process to request assistance in obtaining appointments with Core Specialists within time and distance and timely access standards; and
 - c. Available transportation service to a network or out-of-network providers within or outside of timely access standards.
26. Information on how to report suspected Fraud or Abuse; and
27. Other information as required by DHCS and DMHC.
28. Member procedures for:
- a. Obtaining Covered Services through CalOptima Health's contracted Providers including Primary Care Provider appointments and referrals/prior authorization to specialist care providers;
 - b. Selecting or changing a PCP and/or Health Network;
 - c. Requesting Medical Record transfer when changing PCPs;
 - d. Obtaining Emergency Services within and outside Orange County;
 - e. Receiving a seventy-two (72)-hour supply of medically necessary medication in an emergency situation;
 - f. Obtaining Urgent Care Services; and
 - g. **Medi-Cal:** Scheduling an Initial Health Assessment (IHA) appointment within one hundred twenty (120) calendar days after enrolling in the CalOptima Health program, in accordance with CalOptima Health Policy GG.1613: Initial Health Appointment.
29. **Medi-Cal:** Information on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible Members under the age of twenty-one (21).
- a. Update Member-Facing materials as needed with Medi-Cal for Kids & Teens.
 - b. Publish the DHCS materials and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter on CalOptima Health's website.
 - c. Mail outreach and education materials consisting of age-appropriate material and "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter to new Members under the age of twenty-one (21).
 - i. Materials shall be mailed within seven (7) calendar days of enrollment into CalOptima Health.
 - d. On an annual basis by January 1 of each calendar year, CalOptima Health shall mail or share electronically DHCS supplied materials for existing Members under the age of twenty-one (21).

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- 30. **Medi-Cal:** Information on CalOptima Health’s Member Liaison Program;
 - 31. **Medi-Cal:** Information on how to access State resources for investigation and resolution of Complaints, including a description of the DHCS Medi-Cal Managed Care Ombudsman Program and telephone number;
 - 32. **Medi-Cal:** State hearing procedures and addresses, in accordance with CalOptima Health Policy HH.1108: State Hearings Process and Procedures;
 - 33. **Medi-Cal:** Information on Advance Directives;
 - 34. **Medi-Cal:** Information on how to obtain Minor Consent Services and an explanation of such services;
 - 35. **Medi-Cal:** Information on Sensitive Services;
 - 36. **Medi-Cal:** Availability of services through the Whole-Child Model (WCM) program from Providers outside CalOptima Health’s Provider network and how to access these services;
 - 37. **Medi-Cal:** Information on how to obtain Medi-Cal benefits that are not covered by the CalOptima Health program and an explanation of the fee-for-service system;
 - 38. **Medi-Cal:** Information on transitional Medi-Cal and how a Member may apply for transitional Medi-Cal;
 - 39. **Medi-Cal:** Information on moral objections;
 - 40. **Medi-Cal:** Information on a Member’s right to access an out-of-network provider when there is an Annual Network Certification (ANC) Corrective Action Plan (CAP);
 - 41. **Medi-Cal:** Information on the process for a Member to request out-of-network access due to ANC CAP;
 - 42. **Medi-Cal:** Information on a Member’s right to access services that are usually provided by a Mandatory Provider either in or out of the Service Area, including transportation, if no Mandatory Provider types are available in the Service Area.
 - 43. **Covered California:** Information on how to access the DMHC helpline for resolution of Complaints, including website and phone number;
 - 44. **Covered California:** Information on CalOptima Health’s Drug Formulary;
 - 45. **Covered California:** Information on pharmacy benefits and network;
 - 46. **Covered California:** Information on Enrollment & Eligibility;
 - 47. **Covered California:** Information on payment responsibilities;
 - 48. **Covered California:** Information on disenrollment and cancellations;

- 1 F. **Medi-Cal:** CalOptima Health shall produce and distribute a Member Notice informing Non-Seniors
2 and Persons with Disabilities (SPD) and Dual Eligible Members how to access the Provider
3 Directory, Member Handbook, and Formulary electronically and how to request a paper copy.
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- 5 G. **Medi-Cal:** CalOptima Health shall send, as part of the welcome packet, a paper form of the
6 Provider Directory to all SPD Members and a Member Notice informing Members how to access
7 the Member Handbook and Formulary electronically and how to request a paper copy.
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- 9 H. **Medi-Cal:** CalOptima Health shall submit the CalOptima Health Member Handbook and Member
10 Notice to DHCS for review and approval, in accordance with this policy.
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- 12 I. **Covered California:** Health shall submit the CalOptima Health Member Handbook and Member
13 Notice to DMHC for review and approval, in accordance with this policy.
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- 15 J. A Member welcome packet shall include information on each of the topics listed below:
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- 17 1. Member ID card with Welcome Letter.
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 - 19 2. **Medi-Cal:** A Health Network selection form guide that includes the name, address, and
20 telephone number of all available Health Networks;
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 - 22 3. How to select or change a PCP and Health Network :
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 - 24 a. Procedures for selecting or requesting a PCP and/or Health Network change;
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 - 26 b. Requirements for PCP and/or Health Network change;
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 - 28 c. Reasons a request for PCP and/or Health Network change may be denied;
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 - 30 d. Reasons why a Provider may request a change; and
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 - 32 e. Procedures for requesting transfer of Medical Records when changing PCPs.
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 - 34 4. Procedures for obtaining Urgent Care and Emergency Services within the Health Network's
35 Service Area and outside of the Health Network's Service Area.
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 - 37 5. Other Items:
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 - 39 a. **Medi-Cal:** The purpose and value of scheduling an IHA within one hundred twenty (120)
40 calendar days after enrollment;
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 - 42 b. An insert to inform Members on how to access the Member Handbook/Provider Directory
43 online and how to request a hard copy; and
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 - 45 c. CalOptima Health's Customer Service toll-free telephone number.
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 - 47 6. Other information as required by CalOptima Health.
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- 49 K. A Health Network may submit the Member Welcome Letter to CalOptima Health for review and
50 approval prior to distribution to Members in accordance with Section III.D. of this Policy.
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52 III. PROCEDURE 53

- 1 A. **Medi-Cal:** Upon receipt of the Member's eligibility information from the Department of Health
2 Care Services (DHCS), CalOptima Health shall send a welcome packet. The welcome packet shall
3 include, but not be limited to, the following information:
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- 5 1. New Member Welcome Letter/CalOptima Health Medi-Cal Identification Card;
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 - 7 2. Health Network Selection Form Guide;
 - 8
 - 9 3. Health Network Selection Form;
 - 10
 - 11 4. Summary of Benefits;
 - 12
 - 13 5. New Member Orientation RSVP Form;
 - 14
 - 15 6. Instructions on how to access the Provider Directory and Member Handbook;
 - 16
 - 17 7. Initial Health Appointment Form;
 - 18
 - 19 8. Notice of Non-discrimination and Language Assistance Taglines; and
 - 20
 - 21 9. Postage-paid envelope
 - 22
- 23 B. **Covered California:** Upon receipt of the Member's eligibility information from Covered California
24 and Member Effectuation, CalOptima Health shall send a welcome packet. The welcome packet
25 shall include, but not be limited to, the following information:
26
- 27 1. Welcome Letter
 - 28
 - 29 2. PCP Assignment Notice
 - 30
 - 31 3. ID Card
 - 32
 - 33 4. Summary of Benefits
 - 34
 - 35 5. Pharmacy Benefit Insert
 - 36
 - 37 6. Nurse Advice Line Insert
 - 38
 - 39 7. Electronic Format Insert
 - 40
 - 41 8. Member Rights and Responsibilities Insert
 - 42
 - 43 9. Enrollee Contact Guidelines
 - 44
 - 45 10. Notice of Availability/ Nondiscrimination
 - 46
- 47 C. CalOptima Health Provider Directory, Formulary, and Member Handbook
- 48
 - 49 1. CalOptima Health shall produce the CalOptima Health Provider Directory, Formulary, and
50 Member Handbook at a minimum of twelve (12) point font, with titles and captions at a
51 minimum twelve (12) point bold font, written at no higher than a sixth (6th) grade level, and in
52 all Threshold Languages.
53

2. On an annual basis, CalOptima Health shall submit the CalOptima Health Member Medi-Cal Handbook to DHCS and the CalOptima Health Covered Member Handbook to DMHC for review and approval.
3. **Medi-Cal:** CalOptima Health shall create two (2) distinct welcome packets for SPD and non-SPD Members to ensure SPD Members will continue to receive the paper copy of the Provider Directory.
4. **Medi-Cal:** CalOptima Health shall mail the welcome packet no later than seven (7) calendar days after receipt of the Member's eligibility information from the State, in accordance with CalOptima Health Policies DD.2006: Enrollment in/Eligibility with CalOptima Health Direct and DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment .
5. **Covered California:** CalOptima Health shall mail the welcome packet no later than ten (10) calendar days after Member effectuation, in accordance with CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment
6. **Medi-Cal:** CalOptima Health shall send, to non-SPD Members, a Member Notice informing how to view the Provider Directory, Formulary, and Member Handbook on CalOptima Health's website and how the Member can request a paper copy in accordance with DHCS All Plan Letter (APL) 19-003: Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format.
7. **Medi-Cal:** CalOptima Health shall continue to send, as part of the welcome packets, a paper form of the Provider Directory to SPD Members and notice informing how to view the Formulary and Member Handbook on CalOptima Health's website and how the Member can request a paper copy in accordance with DHCS APL 19-003: Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format.
8. **Medi-Cal:** The Member Notice shall be green in color with the header "Important Plan Information" to be easily identifiable by the Member, a minimum of twelve (12) point font, and written at no higher than a sixth (6th) grade level, and in all Threshold Languages.
9. **Medi-Cal:** On an annual basis, CalOptima Health shall inform a Member of the availability of the CalOptima Health Provider Directory and Member Handbook.
10. CalOptima Health shall provide a Member with the most up-to-date Provider Directory, Formulary and/or Member Handbook within five (5) business days of the Member's request.

D. Member Welcome Letter

1. A Health Network may produce a Member Welcome Letter at a minimum twelve (12) point font, with titles and captions at a minimum twelve (12) point bold font, written at no higher than a sixth (6th) grade level, and in all Threshold Languages.
2. A Health Network shall submit a Member Welcome Letter to CalOptima Health for review and approval prior to distribution to Members.
 - a. CalOptima Health shall make every effort to complete its review of the Member Welcome Letter within thirty (30) calendar days.
3. A Health Network shall submit any updates to the Member Welcome Letter to CalOptima Health for review and approval prior to distribution to Members.

4. A Health Network shall send a Member Welcome Letter to a Member or head of household no later than seven (7) calendar days after receipt of notification that such Member has enrolled in the Health Network.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Health Contract for Healthcare Services
- C. CalOptima Health Policy CC.1200: Member Appeals
- D. CalOptima Health Policy CC.1201: Member Grievance
- E. CalOptima Health Policy DD.2001: Member Rights and Responsibilities
- F. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
- G. CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct
- H. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
- I. CalOptima Health Policy GG.1116: Pediatric Preventive Services
- J. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency and Non-Medical
- K. CalOptima Health Policy GG.1510: Member Appeal Process
- L. CalOptima Health Policy GG.1613: Initial Health Appointment
- M. CalOptima Health Policy HH.1102: Member Grievance
- N. CalOptima Health Policy HH.1108: State Hearings Process and Procedures
- O. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-003: Providing Informing Materials to Medi-Cal Beneficiaries in an Electronic Format
- P. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
- Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
- R. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-005: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services (Supersedes APL 21-004)
- S. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)
- T. Title 42, Code of Federal Regulations (CFR), §§ 438.10(c), 438.10(d) and 438.10(g)

VI. REGULATORY AGENCY APPROVAL

Date	Regulatory Agency	Response
02/11/2011	Department of Health Care Services (DHCS)	Approved as Submitted
02/25/2011	Department of Health Care Services (DHCS)	Approved as Submitted
08/18/2015	Department of Health Care Services (DHCS)	Approved as Submitted
12/24/2019	Department of Health Care Services (DHCS)	Approved as Submitted
10/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
06/05/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/07/2023	Department of Health Care Services (DHCS)	Approved as Submitted
09/09/2026	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	09/01/2004	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2005	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2008	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2009	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2011	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	01/01/2013	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	07/01/2015	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	09/01/2016	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	07/01/2017	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	12/01/2017	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	11/01/2018	DD.2005	Member Handbook Requirements	Medi-Cal
Revised	08/01/2019	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	05/01/2020	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	07/01/2021	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	09/01/2022	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	04/01/2023	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	06/01/2023	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	12/01/2024	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised	12/01/2025	DD.2005	Member Informing Materials Requirements	Medi-Cal
Revised		DD.2005	Member Informing Materials Requirements	Covered California Medi-Cal

1 IX. GLOSSARY
2

Term	Definition
Advanced Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a member is Incapacitate.
Alternative Access Standard (AAS)	An alternative to the existing access standard approved by DHCS when a managed care plan has exhausted all other reasonable options for obtaining providers in order to meet the applicable standards, or if DHCS determines that the requesting managed care plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
Appeal	<u>Covered California</u>: A type of Grievance related to a Member appeal within CalOptima Health's Grievance system. A type of Grievance related to any of the following medical necessity determination or coverage actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability. <u>Medi-Cal</u>: 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).
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Health Members, the CHDP Program is incorporated into CalOptima Health's Pediatric Preventive Services Program.

Term	Definition
Complaint	A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Core Specialist	Adult and pediatric providers as specified in Department of Health Care Services All Plan Letter 20-003: Network Certification Requirements, including Cardiology/Interventional Cardiology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Hematology, HIV/AIDS Specialists/Infectious Diseases, Nephrology, Neurology, Oncology, Ophthalmology, Orthopedic Surgery, Physical Medicine and Rehabilitation, Psychiatry, and Pulmonology.
Covered Services	<u>Covered California</u>: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law. <u>Medi-Cal</u>: Medi-Cal services for which [MCP]CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form).
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs.
Department of Managed Health Care (DMHC)	<u>Covered California</u> : California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.
Emergency Services	<u>Covered California</u>: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in and Health & Safety Code § 1317.1(a)(1) and §1317(a)(2)(A). <u>Medi-Cal</u>: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices;

Term	Definition
	6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
Formulary	<u>Covered California</u>: A list of outpatient prescription drugs, selected by the Plan(s) and revised periodically, which are available to Members. <u>Medi-Cal</u>: The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Health Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
Grievance	<u>Covered California</u>: 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 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. An inquiry is not a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, the incident must be considered a Grievance. A Grievant is the individual making or filing the Grievance. <u>Medi-Cal</u>: 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.
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.

Term	Definition
Mandatory Provider	Providers who managed care plans must offer to contract with, where available, and include Federally Qualified Health Centers (FQHCs), Rural Health Centers, Freestanding Birthing Center (FBC), Certified Nurse Manager, Licensed Midwife, and Indian Health Facilities (IHF), as defined in Department of Health Care Services All Plan Letter 23-001: Network Certification Requirements.
Member	Medi-Cal: For the purposes of this policy, a Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal, or the United States Social Security Administration, who is enrolled in the CalOptima Health program and the CalOptima Health Community Network. Covered California: 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.
Member Welcome Letter	A letter that is prepared and distributed by the Health Network; contains general information about the Health Network.
Minor Consent Services	Those Covered Services of a sensitive nature that a minor does not need parental consent to access, related to: 1. Sexual Assault, including rape; 2. Drug and alcohol abuse for a minor/child twelve (12) years of age or older; 3. Pregnancy; 4. Family planning; and/or 5. Sexually Transmitted Diseases (STDs) for a minor/child twelve (12) years of age or older; and/or 6. Outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or Child abuse.
Pediatric Preventive Services (PPS)	Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the CHDP Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.
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.
Prior Authorizations	<u>Covered California</u>: 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). <u>Medi-Cal</u>: A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.

Term	Definition
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal</u>: 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.
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Service Area	<u>Covered California</u>: The county or counties in which CalOptima Health is approved to operate under the terms of its QHP Contract with the Exchange. The service area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by the Exchange for CalOptima Health to operate under the terms of the QHP Contract. <u>Medi-Cal</u>: The geographical area that DHCS authorizes CalOptima Health to operate in. A Service Area may include designated ZIP Codes within a county that CalOptima Health is approved to operate in.
Specialty Care Provider	Provider of specialty care given to Members by referral by other than a Primary Care Provider.
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS and DMHC.
Urgent Care Services	Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.



Policy: DD.2001
Title: **Member Rights and Responsibilities**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 09/01/2004

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy outlines a Member's rights and responsibilities and the process by which CalOptima Health communicates them to Members.

II. POLICY

A. CalOptima Health and its Health Networks shall inform Members of their rights and responsibilities.

B. CalOptima Health and its Health Networks shall ensure that a Member's rights and responsibilities are respected and observed.

C. Member Rights ~~and Responsibilities~~:

1. ~~To be~~ Receive information about Member rights and responsibilities.

~~1.2. Be~~ treated with respect and dignity, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's Protected Health Information (PHI) and ~~Personal~~ Personally Identifiable Information (PIPII).

~~2.3. To be~~ Be provided with information about CalOptima Health and all services available to Members including Covered Services, Providers, Practitioners, including a clear explanation of how to obtain them and whether CalOptima Health may impose certain limitations on those services.

4. ~~To be~~ Make recommendations regarding CalOptima Health's Member rights and responsibilities policy.

~~3.5. Be~~ able to choose their Primary Care Provider (PCP) within CalOptima Health's Network unless the PCP is unavailable or is not accepting new patients and request a change to another doctor in CalOptima Health's network if the Member is not satisfied.

- 1 ~~6. To participate in decision-making regarding their~~ Receive timely and geographically accessible
2 health care.
- 3
- 4 ~~4.7. Have a timely appointment with a Health Care Provider in CalOptima Health's network,~~
5 including ~~the right to refuse treatment~~ one with a specialist.
- 6
- 7 ~~5. To submit Grievances, either verbally or in writing, about CalOptima Health, Providers, care~~
8 ~~received, and any other expression of dissatisfaction not related to an Adverse Benefit~~
9 ~~Determination (ABD).~~
- 10
- 11 ~~6. To request an Appeal of an ABD within sixty (60) calendar days from the date on the Notice of~~
12 ~~Adverse Benefit Determination (NABD) and how to continue benefits during the in plan~~
13 ~~Appeal process through the State Hearing, when applicable.~~
- 14
- 15 ~~7. To request a State Hearing, including information on the circumstances under which an~~
16 ~~expedited State Hearing is available.~~
- 17
- 18 ~~8. To receive~~ Receive free interpretation services ~~and written translation of critical informing~~
19 ~~materials in their preferred Threshold Language~~ in any language, including oral interpretation,
20 and American Sign Language (ASL).
- 21
- 22 ~~9. To have a valid Advance Directive in place, and an explanation to Members of what an~~
23 ~~Advance Directive is.~~
- 24
- 25 ~~9. To have~~ Receive free written translations, including critical information materials, in their
26 preferred threshold language.
- 27
- 28 10. Have access to family planning services, Sexually Transmitted Disease (STD) services, from a
29 Provider of their choice, without referral or Prior Authorization, either in or outside of
30 CalOptima Health's Network.
- 31
- 32 11. ~~To have~~ Have Emergency Services provided in or outside of CalOptima Health's Network, as
33 required pursuant to federal law.
- 34
- 35 12. ~~To have~~ Have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers
36 (RHCs) and Indian Health Services (IHS) outside of CalOptima Health's Network, pursuant to
37 federal law.
- 38
- 39 13. ~~To have~~ Have access to, and receive a copy of, their Medical Records, and request that they be
40 amended or corrected, as specified in Title 45 Code of Federal Regulations (CFR) Sections
41 164.524 and 164.526 and CalOptima Health Policy GG.1618: Member Request for Medical
42 Records. If the doctor or CalOptima Health denies the Member's request to amend or correct,
43 the Member may add a statement explaining the information.
- 44
- 45 ~~14. To change Medi-Cal managed care plans upon request, if applicable.~~
- 46
- 47 ~~15. To access Minor Consent Services.~~
- 48
- 49 ~~14. To receive~~ Participate with practitioners in decision-making regarding their health care,
50 including giving informed consent when the Member receives treatment. To the extent
51 permitted by law, the Members' right to refuse treatment.
- 52

15. Have a candid discussion of appropriate or medically necessary treatment options for the conditions, regardless of cost or benefit coverage.
16. Request from CalOptima Health for a second opinion by an Appropriately Qualified Health Care Provider.
17. Receive Medically Necessary treatment of a Mental Health or substance use disorder.
18. Protection from illegal balance billing by a Health Care Provider.
19. Have medical information related to sensitive services protected.
20. Be fully informed about CalOptima Health's grievances procedure and understand how to use it without fear of interruption to your health care.
21. Submit Grievances, either verbally or in writing, about CalOptima Health, Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination (ABD).
22. Know why CalOptima Health denies a service or treatment.
23. Request an Appeal of an ABD within sixty (60) calendar days from the date on the Notice of Adverse Benefit Determination (NABD) and how to continue benefits during the in-plan Appeal process through the State Hearing, when applicable.
- ~~16-24.~~ Receive written Member informing materials in alternative formats, including Braille, large size print no smaller than twenty (20) point font, accessible electronic format, and audio format upon request and in accordance with Title 42 CFR Section 438.10, and Title 45 CFR Sections 84.52(d), 92.202.
- ~~17-25.~~ To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- ~~18-26.~~ To receive Receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives.
- ~~19-27.~~ To freely Freely exercise these Member rights without retaliation or any adverse conduct by CalOptima Health, Subcontractors, Downstream Subcontractors, Network Providers, or the State.
- ~~20. To request for Continuity of Care (COC) for Covered Services in accordance with All Plan Letter (APL) 22-2032: Continuity of Care for Medi-Cal beneficiaries who newly enroll in Medi-Cal managed care from Medi-Cal fee-for-service, and for Medi-Cal Members who transition into a new Medi-Cal managed care health plan on or after January 1, 2023 and CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.~~

D. Member's Right to Confidentiality:

- ~~1-28.~~ CalOptima Health and its Health Networks shall ensure Member rights to Have confidentiality of PHI and PIPII in accordance with 45 CFR parts 160 and 164, and in accordance with California Civil Code section 1798 et seq.

~~2.a. CalOptima Health and its Health Networks shall ensure~~Ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, ~~PIPII~~, and any other Confidential Information to any unauthorized persons or entities.

~~3.b. CalOptima Health and its Health Networks shall inform~~Inform and advise Members on the right to confidentiality of their PHI and ~~PIPII~~. CalOptima Health must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by state and federal law.

~~E.29. Member's Right to~~Have information on Advance Directives:

~~1.a. CalOptima Health shall ensure that its process for a Member's right to have an~~Have the Advance Directive ~~in place is~~process included in the Member Handbook.

~~b. Information~~Have the Advance Directive placed in the ~~Member Handbook must include the~~ Member's ~~right to be~~medical records.

~~c. Change or cancel the advance directive at any time.~~

~~2.d. Be~~ informed by CalOptima Health of State law regarding Advance Directives, and to receive information from CalOptima Health regarding any changes to that law.

~~e. CalOptima Health must ensure that the following statement, or similar language provided by DHCS is included:~~

~~a. Advance care planning for Members enrolled in Medi-Cal palliative care, in accordance with DHCS All Plan Letter (APL) 18-020: Palliative Care, must include documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally recognized decision maker. Counseling that takes place during these discussions addresses, but is not limited to, Advance Directives, such as Physician Orders for Life-Sustaining Treatment (POLST) forms.~~

~~4.e. Information on Advance Directives shall comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.~~

~~5.f. CalOptima Health must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained in complying with valid Advance Directives, in accordance with Title 42, CFR Sections 422.128 and 438.3(j).~~

~~30. Medi-Cal: Change Medi-Cal managed care plans upon request, if applicable.~~

~~31. Medi-Cal: Have access to Minor Consent Services.~~

~~32. Medi-Cal: Request for Continuity of Care (COC) for Covered Services in accordance with All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service on or after January 1, 2023 and CalOptima Health Policies CC.1500: Continuity of Care for Members Transitioning into CalOptima Health, and GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.~~

1 33. **Medi-Cal:** Request a State Hearing, including information on the circumstances under which an
2 expedited State Hearing is available.

3
4 34. **Covered California:** Certain accommodations for your disability, including:

- 5
6 a. Equal access to medical services, which includes accessible examination rooms and medical
7 equipment at a Health Care Provider's office or facility.
8
9 b. Full and equal access, as other members of the public, to medical facilities.
10
11 c. Extra time for visits if needed.
12
13 d. Taking their service animal into exam rooms with them.
14

15 ~~F. **Covered** A Member shall have the responsibility:~~

16
17 ~~35. **To know California:** Purchase health insurance or determine Medi-Cal eligibility through the~~
18 ~~California Health Benefit Exchange, Covered California.~~

19
20 36. **Covered California:** Receive culturally competent care, including but not limited to:

- 21
22 a. Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender
23 dysphoria or intersex conditions.
24
25 b. To be addressed by your preferred name and pronoun.
26

27 37. **Covered California:** Receive from their Health Care Provider, upon request, all appropriate
28 information regarding the Member's health problem or medical condition, treatment plan, and
29 any proposed appropriate or Medically Necessary treatment alternatives. This information
30 includes available expected outcomes information, regardless of cost or benefit coverage, so the
31 Member can make an informed decision before they receive treatment.
32

33 38. **Covered California:** Receive health care coverage even if the Member has a pre-existing
34 condition.

35
36 39. **Covered California:** Receive certain preventive health services, including many without a co-
37 pay, co-insurance, or deductible.

38
39 40. **Covered California:** Have no annual or lifetime dollar limits on basic health care services.

40
41 41. **Covered California:** Keep eligible dependent(s) on the Member's Plan.

42
43 42. **Covered California:** Be notified of an unreasonable rate increase or change, as applicable.

44
45 43. **Covered California:** Ask for information regarding who has received personal health
46 information.

47
48 44. **Covered California:** Ask CalOptima Health or the doctor to contact the Member only in
49 certain ways or at certain locations.

50
51
52 45. **Covered California:** Contact the Department of Managed Health Care (DMHC) if the Member
53 has difficulty accessing health care services or has questions about their plan.

1
2 46. **Covered California:** Ask for an Independent Medical Review if Member's plan denied,
3 modified, or delayed a health care service.

4
5 47. **Covered California:** Have an appointment with a Health Care Provider outside of CalOptima
6 Health's network when CalOptima Health cannot provide timely access to care with an in-
7 network Health Care Provider.

8
9 48. **Covered California:** Know the costs for your care, and whether your deductible or out-of-
10 pocket maximum have been met.

11
12 D. Member responsibilities:

13
14 1. Know, understand, and follow the Member handbook.

15
16 2. To understand Treat all Health Care Providers, Health Care Provider staff, and CalOptima
17 Health staff with respect and dignity.

18
19 3. Participate in developing mutually agreed-upon treatment goals with their Health Care
20 Providers and follow the treatment plans and instructions to the degree possible.

21
22 2.4. Understand their medical needs and working with health care Providers to create a mutually
23 agreed-upon treatment plan.

24
25 3.5. To follow Follow treatment plans agreed to with health care Providers.

26
27 4.6. To tell Tell CalOptima Health and health care Providers what they need to know about their
28 medical condition to ensure care.

29
30 5.7. To make Make and keep all scheduled medical appointments and inform the office when they
31 must will be late or need to cancel an appointment.

32
33 6.8. To learn Learn about medical conditions and how to stay healthy.

34
35 7.9. To take Take part in health care programs to stay healthy.

36
37 8.10. To work Provide accurate information to professional staff, following instructions and
38 cooperating with and be polite to health care Providers.

39
40 11. Refrain from submitting false, fraudulent, or misleading claims or information to CalOptima
41 Health or Health Care Providers.

42
43 12. Notify CalOptima Health if there is a change to their name, address, or family members covered
44 under Member's plan.

45
46 13. Notify CalOptima Health as soon as reasonably possible if billed inappropriately.

47
48 14. **Covered California:** Timely pay any premiums, copayments, and charges for non-covered
49 services.

50
51 **III. PROCEDURE**

52
53 A. Informing Members of their rights and responsibilities.

- 1
2 1. CalOptima Health shall inform Members of their rights and responsibilities, as described in this
3 Policy, ~~and in CalOptima Health Policies GG.1507: Notification Requirements for Covered~~
4 ~~Services Requiring Prior Authorization, and HH.1102: Member Grievance~~ as follows:

5
6 a. New Member welcome packet;

7
8 ~~a.b.~~ In the Member Handbook/Evidence of Coverage (EOC) available on the CalOptima Health
9 website (www.caloptimahealth.org) and provided to ~~all~~ Members upon request, in
10 accordance with CalOptima Health Policy DD.2005: Member-Informing Materials
11 Requirements;

12
13 ~~b.c.~~ On CalOptima Health's Website;

14
15 ~~e.d.~~ Annually in the Member newsletter; and

16
17 ~~d.e.~~ Upon a Member's request.

- 18
19 2. A Provider shall post a Member's rights and responsibilities, as described in this Policy, in the
20 waiting room of the facility in which he or she renders services to Members.

21
22 B. A Member may file a Grievance, including a Grievance alleging discrimination in accordance with
23 CalOptima Health Policies CC.1201: Member Grievance, DD.2013: Customer Service Grievance
24 Process, HH.1102: Member Grievance, and HH.1104: Complaints of Discrimination, ~~and HH.1103:~~
25 ~~Health Network Member Grievance and Appeal Process~~, if the Member believes their rights, as
26 described in Section II.C. of this Policy, have not been respected, or observed.

27
28 **IV. ATTACHMENT(S)**

29
30 Not Applicable

31
32 **V. REFERENCE(S)**

33
34 A. California Code, Civil Code § 1798 et seq.

35 B. California Welfare & Institutions Code (WIC) § 14182 (b)(12)

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

37 ~~B.D.~~ CalOptima Health Contract for Health Care Services

38 E. CalOptima Health Covered Combined Evidence of Coverage and Disclosure Form

39 ~~C.F.~~ CalOptima Health Member Handbook/Evidence of Coverage (EOC)

40 G. CalOptima Health Policy CC.1201: Member Grievance

41 H. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima
42 Health

43 ~~D.I.~~ CalOptima Health Policy DD.2005: Member-Informing Materials Requirements

44 ~~E.J.~~ CalOptima Health Policy DD.2013: Customer Service Grievance Process

45 ~~F.K.~~ CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into
46 CalOptima Health Services

47 ~~G.~~ CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring
48 Prior Authorization

49 H.L. CalOptima Health Policy GG.1618: Member Request for Medical Records

50 I.M. CalOptima Health Policy HH.1102: Member Grievance

51
52 ~~J.N.~~ CalOptima Health Policy HH.1104: Complaints of Discrimination

53 K.O. CalOptima Health Policy HH.3004: Member Request to Amend Records

~~L.P.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020: Palliative Care (Supersedes APL 17-015)

~~M.Q.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, ~~and for Medi-Cal members who transition into a new Medi-Cal Managed Care Health Plan on or after January 1, 2023, (supersedes APL 22-032)~~

~~N.A.~~ ~~California Welfare & Institutions Code (WIC) § 14182 (b)(12)~~

~~O.A.~~ ~~California Code, Civil Code § 1798 et seq.~~

~~P.R.~~ Title 42, Code of Federal Regulations (CFR), §§ 164.524, 164.526, 422.128, 438.3(j), and 438.10

~~Q.S.~~ Title 45, Code of Federal Regulations (CFR), §§ 84.52(d), 92.202, 164.524 and 164.526

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/28/2009	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2009	Department of Health Care Services (DHCS)	Approved as Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
02/25/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/15/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/19/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use
09/09/2026	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
02/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2008	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	07/01/2009	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	03/01/2011	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2013	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2014	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2016	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	06/01/2017	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	08/01/2018	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2019	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	02/03/2022	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	04/01/2023	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	06/01/2023	DD.2001	Member Rights and Responsibilities	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2023	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	05/01/2024	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2025	DD.2001	Member Rights and Responsibilities	Medi-Cal
<u>Revised</u>		<u>DD.2001</u>	<u>Member Rights and Responsibilities</u>	<u>Covered California Medi-Cal</u>

1

For 20261001 BOD Review Only

IX. GLOSSARY

Term	Definition
Advance Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a member is incapacitated.
Appeal	<u>Covered California: A type of Grievance related to a Member appeal within CalOptima Health's Grievance system. A type of Grievance related to any of the following medical necessity determination or coverage actions taken by CalOptima Health:</u> <u>1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.</u> <u>2. The reduction, suspension, or termination of a previously authorized service.</u> <u>3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a).</u> <u>4. The failure to provide services in a timely manner.</u> <u>5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals.</u> <u>6. The denial of a Member's request to dispute financial liability.</u> <u>Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions:</u> <u>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;</u> <u>2. A reduction, suspension, or termination of a previously authorized service;</u> <u>3. A denial, in whole or in part, of payment for a service;</u> <u>4. Failure to provide services in a timely manner; or</u> <u>5. Failure to act within the timeframes provided in 42 CFR 438.408(b).</u>
Authorized Representative	<u>Covered California: 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 DHCS State Fair Hearings, 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</u>

Term	Definition
	<u>Member who does not have legal capacity to appoint an authorized assistant.</u> <u>Medi-Cal:</u> Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
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 Covered California: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law. Medi-Cal: Medi-Cal services for which [MCP]CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form). 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,

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;

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.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).

Term	Definition
Grievance	<u>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 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. An inquiry is not a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, the incident must be considered a Grievance. A Grievant is the individual making or filing the Grievance.</u> <u>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.</u>
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.
Indian Health Services Facility	Facilities operated with funds from the Indian Health Service (HIS) under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Key Points of Contact	Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.
Medically Necessary or Medical Necessity	<u>Covered California: 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</u>

Term	Definition
	<u>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).</u> Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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 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. <u>An individual enrolled in a CalOptima Health program.</u>
Member Information	Documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory, welcome packets, Marketing information, form letters including Notice Of Actions (NOA), notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, Contractor's preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.

Term	Definition
Minor Consent Services	Those covered services of a sensitive nature that a minor does not need parental consent to access, related to: 1. Sexual Assault, including rape; 2. Drug and alcohol abuse for a minor/child twelve (12) years of age or older; 3. Pregnancy; 4. Family planning; 5. Sexually Transmitted Diseases (STDs) for a minor/child twelve (12) years of age or older; and/or 6. Outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or Child abuse.
Network Provider	<u>Covered California: Any provider as defined in HSC § 1345(i) located inside or outside of the Network Service Area of a designated network who meets all of the following criteria listed in Title 28 CCR § 1300.67.2.2(b)(10).</u> <u>Medi-Cal:</u> Any Provider or entity that has a Network Provider Agreement with CalOptima Health, CalOptima Health's Subcontractor, or CalOptima Health's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the Department of Health Care Services contract for Medi-Cal. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Notice of Action (NOA)	A formal letter from CalOptima Health informing a Member of an "Adverse Benefit Determination."
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	<u>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.</u> <u>Medi-Cal:</u> Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Rural Health Clinic (RHC)	An entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.
State Hearing	A hearing with an Administrative Law Judge to resolve a Member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.

Term	Definition
Subcontractor	<u>Covered California: An individual or entity that has an agreement with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's services under this Agreement. A provider is not a Subcontractor solely because it enters into a provider agreement.</u> <u>Medi-Cal:</u> An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.



Policy: DD.2001
Title: **Member Rights and Responsibilities**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 09/01/2004

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy outlines a Member's rights and responsibilities and the process by which CalOptima Health communicates them to Members.

II. POLICY

- A. CalOptima Health and its Health Networks shall inform Members of their rights and responsibilities.
- B. CalOptima Health and its Health Networks shall ensure that a Member's rights and responsibilities are respected and observed.
- C. Member Rights:
1. Receive information about Member rights and responsibilities.
 2. Be treated with respect and dignity, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's Protected Health Information (PHI) and Personally Identifiable Information (PII).
 3. Be provided with information about CalOptima Health and all services available to Members including Covered Services, Providers, Practitioners, including a clear explanation of how to obtain them and whether CalOptima Health may impose certain limitations on those services.
 4. Make recommendations regarding CalOptima Health's Member rights and responsibilities policy.
 5. Be able to choose their Primary Care Provider (PCP) within CalOptima Health's Network unless the PCP is unavailable or is not accepting new patients and request a change to another doctor in CalOptima Health's network if the Member is not satisfied.
 6. Receive timely and geographically accessible health care.

- 1 7. Have a timely appointment with a Health Care Provider in CalOptima Health's network,
2 including one with a specialist.
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- 4 8. Receive free interpretation services in any language, including oral interpretation, and American
5 Sign Language (ASL).
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- 7 9. Receive free written translations, including critical information materials, in their preferred
8 threshold language.
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- 10 10. Have access to family planning services, Sexually Transmitted Disease (STD) services, from a
11 Provider of their choice, without referral or Prior Authorization, either in or outside of
12 CalOptima Health's Network.
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- 14 11. Have Emergency Services provided in or outside of CalOptima Health's Network, as required
15 pursuant to federal law.
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- 17 12. Have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and
18 Indian Health Services (IHS) outside of CalOptima Health's Network, pursuant to federal law.
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- 20 13. Have access to, and receive a copy of, their Medical Records, and request that they be amended
21 or corrected, as specified in Title 45 Code of Federal Regulations (CFR) Sections 164.524 and
22 164.526 and CalOptima Health Policy GG.1618: Member Request for Medical Records. If the
23 doctor or CalOptima Health denies the Member's request to amend or correct, the Member may
24 add a statement explaining the information.
- 25
- 26 14. Participate with practitioners in decision-making regarding their health care, including giving
27 informed consent when the Member receives treatment. To the extent permitted by law, the
28 Members' right to refuse treatment.
- 29
- 30 15. Have a candid discussion of appropriate or medically necessary treatment options for the
31 conditions, regardless of cost or benefit coverage.
- 32
- 33 16. Request from CalOptima Health for a second opinion by an Appropriately Qualified Health
34 Care Provider.
- 35
- 36 17. Receive Medically Necessary treatment of a Mental Health or substance use disorder.
- 37
- 38 18. Protection from illegal balance billing by a Health Care Provider.
- 39
- 40 19. Have medical information related to sensitive services protected.
- 41
- 42 20. Be fully informed about CalOptima Health's grievances procedure and understand how to use it
43 without fear of interruption to your health care.
- 44
- 45 21. Submit Grievances, either verbally or in writing, about CalOptima Health, Providers, care
46 received, and any other expression of dissatisfaction not related to an Adverse Benefit
47 Determination (ABD).
- 48
- 49 22. Know why CalOptima Health denies a service or treatment.
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- 51 23. Request an Appeal of an ABD within sixty (60) calendar days from the date on the Notice of
52 Adverse Benefit Determination (NABD) and how to continue benefits during the in-plan
53 Appeal process through the State Hearing, when applicable.

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- 24. Receive written Member informing materials in alternative formats, including Braille, large size print no smaller than twenty (20) point font, accessible electronic format, and audio format upon request and in accordance with Title 42 CFR Section 438.10, and Title 45 CFR Sections 84.52(d), 92.202.
 - 25. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - 26. Receive information on available treatment options and alternatives, presented in a manner appropriate for the Member's condition and ability to understand available treatment options and alternatives.
 - 27. Freely exercise these Member rights without retaliation or any adverse conduct by CalOptima Health, Subcontractors, Downstream Subcontractors, Network Providers, or the State.
 - 28. Have confidentiality of PHI and PII in accordance with 45 CFR parts 160 and 164, and in accordance with California Civil Code section 1798 et seq.
 - a. Ensure that all Subcontractors, Downstream Subcontractors, and Network Providers have policies and procedures in place to guard against unlawful disclosure of PHI, PII, and any other Confidential Information to any unauthorized persons or entities.
 - b. Inform and advise Members on the right to confidentiality of their PHI and PII. CalOptima Health must obtain the Member's prior written authorization to release Confidential Information, unless such prior written authorization is not required by state and federal law.
 - 29. Have information on Advance Directives:
 - a. Have the Advance Directive process included in the Member Handbook
 - b. Have the Advance Directive placed in the Member's medical records.
 - c. Change or cancel the advance directive at any time.
 - d. Be informed by CalOptima Health of State law regarding Advance Directives, and to receive information from CalOptima Health regarding any changes to that law.
 - e. Information on Advance Directives shall comply with all State and federal law requirements and must be updated to reflect any changes to laws governing Advance Directives.
 - f. CalOptima Health must ensure its Network Providers, Subcontractors, and Downstream Subcontractors are trained in complying with valid Advance Directives, in accordance with Title 42, CFR Sections 422.128 and 438.3(j).
 - 30. **Medi-Cal:** Change Medi-Cal managed care plans upon request, if applicable.
 - 31. **Medi-Cal:** Have access to Minor Consent Services.
 - 32. **Medi-Cal:** Request for Continuity of Care (COC) for Covered Services in accordance with All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service on or after January 1, 2023 and

CalOptima Health Policies CC.1500: Continuity of Care for Members Transitioning into CalOptima Health, and GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.

33. **Medi-Cal:** Request a State Hearing, including information on the circumstances under which an expedited State Hearing is available.
34. **Covered California:** Certain accommodations for your disability, including:
 - a. Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
 - b. Full and equal access, as other members of the public, to medical facilities.
 - c. Extra time for visits if needed.
 - d. Taking their service animal into exam rooms with them.
35. **Covered California:** Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
36. **Covered California:** Receive culturally competent care, including but not limited to:
 - a. Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
 - b. To be addressed by your preferred name and pronoun.
37. **Covered California:** Receive from their Health Care Provider, upon request, all appropriate information regarding the Member's health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so the Member can make an informed decision before they receive treatment.
38. **Covered California:** Receive health care coverage even if the Member has a pre-existing condition.
39. **Covered California:** Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
40. **Covered California:** Have no annual or lifetime dollar limits on basic health care services.
41. **Covered California:** Keep eligible dependent(s) on the Member's Plan.
42. **Covered California:** Be notified of an unreasonable rate increase or change, as applicable.
43. **Covered California:** Ask for information regarding who has received personal health information.
44. **Covered California:** Ask CalOptima Health or the doctor to contact the Member only in certain ways or at certain locations.

- 1 45. **Covered California:** Contact the Department of Managed Health Care (DMHC) if the Member
2 has difficulty accessing health care services or has questions about their plan.
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4 46. **Covered California:** Ask for an Independent Medical Review if Member's plan denied,
5 modified, or delayed a health care service.
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7 47. **Covered California:** Have an appointment with a Health Care Provider outside of CalOptima
8 Health's network when CalOptima Health cannot provide timely access to care with an in-
9 network Health Care Provider.
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11 48. **Covered California:** Know the costs for your care, and whether your deductible or out-of-
12 pocket maximum have been met.
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14 D. Member responsibilities:

- 15 1. Know, understand, and follow the Member handbook.
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17 2. Treat all Health Care Providers, Health Care Provider staff, and CalOptima Health staff with
18 respect and dignity.
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20 3. Participate in developing mutually agreed-upon treatment goals with their Health Care
21 Providers and follow the treatment plans and instructions to the degree possible.
22
23 4. Understand their medical needs and working with health care Providers to create a mutually
24 agreed-upon treatment plan.
25
26 5. Follow treatment plans agreed to with health care Providers.
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28 6. Tell CalOptima Health and health care Providers what they need to know about their medical
29 condition to ensure care.
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31 7. Make and keep all scheduled medical appointments and inform the office when they will be late
32 or need to cancel.
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34 8. Learn about medical conditions and how to stay healthy.
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36 9. Take part in health care programs to stay healthy.
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38 10. Provide accurate information to professional staff, following instructions and cooperating with
39 health care Providers.
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41 11. Refrain from submitting false, fraudulent, or misleading claims or information to CalOptima
42 Health or Health Care Providers.
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44 12. Notify CalOptima Health if there is a change to their name, address, or family members covered
45 under Member's plan.
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47 13. Notify CalOptima Health as soon as reasonably possible if billed inappropriately.
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49 14. **Covered California:** Timely pay any premiums, copayments, and charges for non-covered
50 services.
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III. PROCEDURE

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2 A. Informing Members of their rights and responsibilities.
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4 1. CalOptima Health shall inform Members of their rights and responsibilities, as described in this
5 Policy as follows:
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- 7 a. New Member welcome packet;
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9 b. In the Member Handbook/Evidence of Coverage (EOC) available on the CalOptima Health
10 website (www.caloptimahealth.org) and provided to Members upon request, in accordance
11 with CalOptima Health Policy DD.2005: Member-Informing Materials Requirements;
12
13 c. On CalOptima Health's Website;
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15 d. Annually in the Member newsletter; and
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17 e. Upon a Member's request.
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19 2. A Provider shall post a Member's rights and responsibilities, as described in this Policy, in the
20 waiting room of the facility in which he or she renders services to Members.
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22 B. A Member may file a Grievance, including a Grievance alleging discrimination in accordance with
23 CalOptima Health Policies CC.1201: Member Grievance, DD.2013: Customer Service Grievance
24 Process, HH.1102: Member Grievance, and HH.1104: Complaints of Discrimination, if the Member
25 believes their rights, as described in Section II.C. of this Policy, have not been respected, or
26 observed.
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28 **IV. ATTACHMENT(S)**
29

30 Not Applicable
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32 **V. REFERENCE(S)**
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- 34 A. California Code, Civil Code § 1798 et seq.
35 B. California Welfare & Institutions Code (WIC) § 14182 (b)(12)
36 C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
37 D. CalOptima Health Contract for Health Care Services
38 E. CalOptima Health Covered Combined Evidence of Coverage and Disclosure Form
39 F. CalOptima Health Member Handbook/Evidence of Coverage (EOC)
40 G. CalOptima Health Policy CC.1201: Member Grievance
41 H. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima
42 Health
43 I. CalOptima Health Policy DD.2005: Member-Informing Materials Requirements
44 J. CalOptima Health Policy DD.2013: Customer Service Grievance Process
45 K. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima
46 Health Services
47 L. CalOptima Health Policy GG.1618: Member Request for Medical Records
48 M. CalOptima Health Policy HH.1102: Member Grievance
49 N. CalOptima Health Policy HH.1104: Complaints of Discrimination
50 O. CalOptima Health Policy HH.3004: Member Request to Amend Records
51 P. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020: Palliative Care
52 (Supersedes APL 17-015)

- Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service on or after January 1, 2023, (supersedes APL 22-032)
- R. Title 42, Code of Federal Regulations (CFR), §§ 164.524, 164.526, 422.128, 438.3(j), and 438.10
- S. Title 45, Code of Federal Regulations (CFR), §§ 84.52(d), 92.202, 164.524 and 164.526

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/28/2009	Department of Health Care Services (DHCS)	Approved as Submitted
10/12/2009	Department of Health Care Services (DHCS)	Approved as Submitted
01/26/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
02/25/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/03/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/15/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/19/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use
09/09/2026	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
02/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2004	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2008	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	07/01/2009	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	03/01/2011	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2013	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2014	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2016	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	06/01/2017	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	08/01/2018	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	01/01/2019	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	02/03/2022	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	04/01/2023	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	06/01/2023	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	10/01/2023	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	05/01/2024	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised	09/01/2025	DD.2001	Member Rights and Responsibilities	Medi-Cal
Revised		DD.2001	Member Rights and Responsibilities	Covered California Medi-Cal

1 IX. GLOSSARY

2

Term	Definition
Advance Directives	A written instruction such as a living will or durable power of attorney for health care, recognized under state law, relating to the provision of health care when a member is incapacitated.
Appeal	<u>Covered California</u>: A type of Grievance related to a Member appeal within CalOptima Health's Grievance system. A type of Grievance related to any of the following medical necessity determination or coverage actions taken by CalOptima Health: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a complete claim as specified in 28 CCR 1300.71(a). 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. The denial of a Member's request to dispute financial liability. <u>Medi-Cal</u>: 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).
Authorized Representative	<u>Covered California</u>: 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 DHCS State Fair Hearings, 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

Term	Definition
	Member who does not have legal capacity to appoint an authorized assistant. <u>Medi-Cal</u>: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Covered Services	<u>Covered California</u>: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law. <u>Medi-Cal</u>: Medi-Cal services for which [MCP]CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form).
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(1)(2)(B)).
Grievance	<u>Covered California:</u> 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 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. An inquiry is not a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, the incident must be considered a Grievance. A Grievant is the individual making or filing the Grievance. <u>Medi-Cal:</u> 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.

Term	Definition
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.
Indian Health Services Facility	Facilities operated with funds from the Indian Health Service (HIS) under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Key Points of Contact	Service sites for Members consisting of medical and non-medical points of contact. Medical points of contact may include face-to-face or telephone encounters with Providers that provide medical or health care services and advice to Members, including pharmacists. Non-medical points of contact may include, but are not limited to, membership services, appointment services, or Member orientation meetings.
Medically Necessary or Medical Necessity	<u>Covered California</u>: 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). <u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve,

Term	Definition
	support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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	An individual enrolled in a CalOptima Health program.
Member Information	Documents that are vital, or critical to obtaining benefits or services, and includes, but is not limited to: the Member Handbook, Provider Directory, welcome packets, Marketing information, form letters including Notice Of Actions (NOA), notices related to Grievances or Appeals, including Grievance and Appeal acknowledgement and resolution letters, Contractor's preventive health reminders, Member surveys, notices advising of the availability of free language assistance, and newsletters.
Minor Consent Services	Those covered services of a sensitive nature that a minor does not need parental consent to access, related to: 1. Sexual Assault, including rape; 2. Drug and alcohol abuse for a minor/child twelve (12) years of age or older; 3. Pregnancy; 4. Family planning; 5. Sexually Transmitted Diseases (STDs) for a minor/child twelve (12) years of age or older; and/or 6. Outpatient mental health care for children twelve (12) years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or Child abuse.
Network Provider	<u>Covered California:</u> Any provider as defined in HSC § 1345(i) located inside or outside of the Network Service Area of a designated network who meets all of the following criteria listed in Title 28 CCR § 1300.67.2.2(b)(10). <u>Medi-Cal:</u> Any Provider or entity that has a Network Provider Agreement with CalOptima Health, CalOptima Health's Subcontractor, or CalOptima Health's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the Department of Health Care Services contract for Medi-Cal. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.
Notice of Action (NOA)	A formal letter from CalOptima Health informing a Member of an "Adverse Benefit Determination."
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.

Term	Definition
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal</u>: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Rural Health Clinic (RHC)	An entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.
State Hearing	A hearing with an Administrative Law Judge to resolve a Member's dispute about an action taken by Contractor, its Network Providers, Subcontractors, or Downstream Subcontractors.
Subcontractor	<u>Covered California</u>: An individual or entity that has an agreement with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's services under this Agreement. A provider is not a Subcontractor solely because it enters into a provider agreement. <u>Medi-Cal</u>: An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.



Policy: DD.2012
Title: **Member Notification of Change in Location or Availability of Providers or Covered Services**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 11/01/2011

Revised Date:

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

I. PURPOSE

This policy defines the process by which CalOptima Health, or a Health Network, shall notify a Member of any change in location or availability of ~~providers~~ Health Care Providers or Covered Services.

II. POLICY

A. CalOptima Health or a Health Network shall ensure that Members are notified in a timely manner of any changes in the availability of Network Providers or location of Covered Services, as described in this Policy and in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network and Subcontractor Terminations and Department of Managed Health Care (DMHC) All Plan Letter 19-013: Block Transfer Member Transfer Notices, resulting from, but not limited to:

1. Changes in the hours, days, or location at which Covered Services are available; or
2. Termination, or non-renewal of a CalOptima Health or Health Network Provider's contract with CalOptima Health.
3. State or federal government suspension, or exclusion from participation in the Medicaid or Medicare program. Suspension or exclusion may occur when an individual or entity is:
 - a. Convicted of a felony;
 - b. Convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualification, functions, or duties of a provider of service;
 - c. Suspended from the Medicare or Medicaid programs for any reason; or
 - d. Lost or surrendered a license, certificate, or approval to provide care.

- 1 B. CalOptima Health shall be responsible for notifying Members of any changes to their assigned
2 Primary Care Provider, as described in this Policy.
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- 4 C. Health Networks shall be responsible for notifying Members enrolled with the respective Health
5 Network of any changes to specialty care providers, as described in this Policy.
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- 7 D. CalOptima Health or a Health Network shall provide written notice to all impacted Members
8 informing them of the contract termination either thirty (30) calendar days prior to the effective date
9 of the contract termination or fifteen (15) calendar days after receipt or issuance of the termination,
10 whichever is later, unless directed by DHCS or DMHC.
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- 12 E. If CalOptima Health or a Health Network is notified of a contract termination less than thirty (30)
13 calendar days prior to the effective date of termination, CalOptima Health or a Health Network shall
14 immediately notify all impacted Members of the termination.
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- 16 F. For the California Department of Public Health (CDPH) Initiated Facility Decertification and
17 Suspensions, CalOptima Health shall work with the facility to ensure that Members continue to
18 receive Medically Necessary Covered Services and Member notices shall include the information
19 outlined in Section III.D. of this Policy.
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- 21 1. If the facility is residential and remains open, Members shall have at least thirty (30) days post-
22 notice to transition to a new facility, with the following exceptions:
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- 24 a. The safety of a Member in a facility (e.g., skilled nursing facility (SNF)) is endangered;
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- 26 b. The health of a Member in a facility is endangered;
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- 28 c. A Member's health improves sufficiently so that the Member no longer requires the
29 services provided by the facility;
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- 31 d. A Member's urgent medical needs require an immediate transfer or discharge;
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- 33 e. A Member has not resided in a facility for thirty (30) days or more;
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- 35 f. A Member, their guardian, conservator, or Authorized Representative has requested a
36 transition to another facility; or
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- 38 g. A facility closes or is no longer operational.
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- 40 G. In the event of a natural disaster or emergency, CalOptima Health or a Health Network shall notify
41 Members of any changes in the availability or location of Covered Services, as soon as possible, and
42 within fourteen (14) calendar days of the change.
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- 44 H. In the case of unforeseen circumstances, (i.e., if CalOptima Health or a Health Network receives
45 inadequate notice of a change in the Network Provider contract status and is unable to notify
46 Members in writing at least thirty (30) calendar days prior to the effective date of the termination),
47 CalOptima Health or a Health Network shall notify Members of the change within fifteen (15)
48 calendar days after receipt or issuance of the termination notice to each Member who received his or
49 her primary care from, or was seen on a regular basis by, the terminated Network Provider.
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- 51 I. Member notices shall include the information as outlined in Sections III.C. and III.D of this Policy.
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- J. If a contract is successfully renegotiated with a CalOptima Health Network Provider before the effective date of the contract termination, and Member notices have already been mailed, CalOptima Health shall mail another notice to inform Members that the contract is not being terminated. CalOptima Health may submit a template notice for DHCS approval and must include information as described in Section III.E. of this Policy.
- K. CalOptima Health or a Health Network shall notify Members in writing of any changes in the availability or location of Covered Services, ~~providers~~Health Care Providers, or any other changes in information, at least thirty (30) calendar days prior to the effective date of such changes, unless otherwise specified in this Policy.
1. CalOptima Health shall obtain approval from DHCS prior to making any substantial change in the availability or location of Covered Services, including, but not limited to, any proposal to reduce or change the hours, days, or location at which the services are available in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.
 2. CalOptima Health may use a template notice previously approved by DHCS if no changes were made. If CalOptima Health makes a change to a DHCS-approved template, or does not have an approved template on file, the notice must be submitted to DHCS for review and approval prior to mailing to Members.
- L. For Network Provider terminations affecting two thousand (2,000) or more Members, or if there are Members who cannot be reassigned to a PCP within required time and/or distance standards as described in CalOptima Health Policy GG.1600: Access and Availability Standards, CalOptima Health shall submit the written Member notice as well as a narrative or transition plan of how CalOptima Health shall intend to provide Covered Services to affected Members at least sixty (60) calendar days prior to the expected date of termination to DHCS for review and approval in accordance with this policy and CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.
- M. For Network Provider terminations affecting fewer than two thousand (2,000) Members, CalOptima Health can reassign all affected Members to a Network Provider, as applicable, within required time as distance standards as described in CalOptima Health Policy GG.1600: Access and Availability Standards, CalOptima Health may send the written Member notification that was previously reviewed and approved by DHCS.
- N. A Health Network shall notify CalOptima Health of a change in the availability or location of Covered Services; a termination of a Network Provider, including but may not be limited to, PCP, Community Health Center, contracted Health Network, IPA, medical group or hospital contract; or any other changes in information, in accordance with this Policy and CalOptima Health Policies EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.
1. For Network Provider, including but may not be limited to, PCP, Community Health Center, IPA or medical group terminations, a Health Network must submit the written Member notices to the CalOptima Health, Health Network Relations Department at least ninety (90) calendar days in advance of the intended date of distribution to Members, unless the notice is for PCP and Community Clinic terminations as described in Section II.K. of this Policy and is already approved by DHCS;

- 1 2. For contracted hospital terminations, a Health Network must submit the written Member notices
2 to the CalOptima Health, Health Network Relations Department at least sixty (60) calendar days
3 prior to the expected date of termination; and
4
- 5 3. If a written Member notice has not been approved by DHCS, CalOptima Health shall obtain
6 approval prior to its release to Members.
7
- 8 O. DHCS will notify CalOptima Health of any Medi-Cal ~~providers~~ Health Care Providers that have
9 been suspended, terminated, or decertified from participating in the Medi-Cal program. CalOptima
10 Health or a Health Network shall take action pursuant to Section III.F of this Policy.
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- 12 1. In the case of an immediate closure by the California Department of Public Health (CDPH),
13 CDPH is responsible for the transition of affected Members. CalOptima Health or a Health
14 Network shall track the transition of these Members and coordinate care, as needed.
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- 16 P. CalOptima Health may modify the notification period identified in this Policy if it deems it to be in
17 the best interest of the Member, CalOptima Health, or a Health Network.
18
- 19 Q. CalOptima Health or a Health Network shall ensure continuity of care during Network Provider
20 terminations, or in the event the Member is required to change Health Networks, due to a Health
21 Network participation status in the CalOptima Health Medi-Cal program in accordance with
22 CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider
23 Termination.
24
- 25 R. **Covered California:** CalOptima Health shall submit their Block Transfer Filings to DMHC for
26 review. The filing must include an example or "template" of the written Member Transfer Notice
27 (ETN) CalOptima Health intends to send to affected Members regarding the date of the contract
28 termination and reassignment (or redirection) to a new provider group (or hospital). The DMHC
29 reviews the template ETNs to ensure the documents include all information required by law. In
30 addition, California Code of Regulations, Title 22, Sections 53852 and 53911 require Medi-Cal
31 managed care health plans to obtain written approval from the Department of Health Care Services
32 (DHCS) prior to making any substantial change in the availability or location of Covered Services.
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34 III. PROCEDURE

35 A. Health Network Notification to CalOptima Health

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- 37 1. A Health Network shall notify the CalOptima Health, Provider Relations Department of a
38 change in the availability or location of Covered Services, or a termination of a Network
39 Provider and/or Subcontractor.
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- 41 2. A Health Network shall submit written Member notices to the CalOptima Health, Health
42 Network Relations Department for review prior to distribution to Members in accordance with
43 Section II.O. of this Policy.
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- 45 a. The CalOptima Health, Health Network Relations Department shall submit written Member
46 notices to the CalOptima Health Regulatory Affairs & Compliance Department for
47 submission to DHCS prior to distribution to Members. Upon receipt of the response from
48 DHCS, the CalOptima Health Regulatory Affairs & Compliance Department shall notify
49 the CalOptima Health, Health Network Relations Department.
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- 1 b. A Health Network shall be responsible for notifying Members pursuant to the specified
2 timelines detailed in this policy. A Health Network shall notify the CalOptima Health,
3 Health Network Relations Department of the date of the mailings and the number of
4 Members receiving the written notification.
5
- 6 3. A Health Network shall submit a narrative or transition plan to the CalOptima Health, Health
7 Network Relations Department detailing how the Health Network intends to continue to provide
8 Covered Services to affected Members. This narrative or transition plan shall be submitted to
9 DHCS by CalOptima Health in accordance with CalOptima Health Policy GG.1652: DHCS
10 Notification of Change in the Availability or Location of Covered Services.
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- 12 B. The CalOptima Health Contracting Department or Provider Relations Department shall notify
13 CalOptima Health Customer Service Department of a change in the availability or location of
14 Covered Services for Health Network ~~providers~~Providers, in accordance with this Policy.
15
- 16 1. The CalOptima Health Customer Service Department shall submit written Member notices to
17 the CalOptima Health Regulatory Affairs & Compliance Department for submission to DHCS
18 prior to distribution to Members in accordance with this Policy. Upon receipt of the response
19 from DHCS, the CalOptima Health Regulatory Affairs & Compliance Department shall notify
20 the CalOptima Health Customer Service Department.
21
- 22 2. The CalOptima Health Case Management, Long Term Services and Supports (LTSS) or Health
23 Network Relations Departments shall submit the narrative description or transition plan of how
24 CalOptima Health or a Health Network shall intend to provide Covered Services to affected
25 Members in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change
26 in the Availability or Location of Covered Services.
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- 28 C. Medi-Cal: Member notification for termination of a Network Provider, including a PCP,
29 Community Health Center, Health Network, IPA, medical group, or hospital:
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- 31 1. CalOptima Health's or the Health Network's written notice to Members shall include, at a
32 minimum, the following:
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- 34 a. Effective date of the contract termination;
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- 36 b. A description of how the contract termination will impact the Member's access to Covered
37 Services, if applicable;
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- 39 c. Name of the terminating/terminated Network Provider/Subcontractor;
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- 41 d. Name of the new Network Provider/Subcontractor that the Member is being assigned to, if
42 applicable;
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- 44 e. Member rights information on how to request a new ~~provider~~Health Care Provider if the
45 Member elects to change from the ~~provider~~Health Care Provider CalOptima Health
46 reassigned them to;
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- 48 f. If applicable, the name of another hospital the Member will be assigned to or can access in
49 the service area;
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- 51 g. All language required by Health and Safety Code (HSC) Section 1373.65, including the
52 Member's Continuity of Care (COC) rights to the terminating/terminated Network

Provider/Subcontractor, unless the Network Provider/Subcontractor has been excluded from participating in the Medi-Cal Program; and

h. Language providing the Member with CalOptima Health or Health Network Customer Services telephone number and the toll-free telephone number of DHCS' Office of the Ombudsman.

2. CalOptima Health's Customer Service Department, with the assistance of other operational departments, as needed, will assist the Member in selecting a new PCP or ~~provider~~Health Care Provider, upon request.

D. Upon discovery of a Long-Term Care (LTC) Facility decertification or suspension, CalOptima Health shall terminate its contract with the facility, and provide notice to all impacted Members within five (5) calendar days of receiving notification of the closure or effective date of the termination, and at a minimum must include the following information:

1. Effective date of the contract termination;
2. The name of the LTC Facility;
3. The reason for the decertification;
4. A description of how the decertification will impact the Member's access to covered services;
5. All language required by HSC Section 1373.65;
6. Language providing the member with CalOptima Health's Member Services telephone number and the toll-free telephone number of DHCS' Office of the Ombudsman for questions or concerns;
7. A description of how the CalOptima Health will maintain the ability to provide covered services to impacted Members; and
8. The date the member notice will be mailed.

E. **Covered California:** CalOptima Health shall include the following information in the ETNs when there is a contract termination with a general acute care hospital:

1. The name of the terminating general acute hospital.
2. A brief explanation as to why the redirection to alternate hospitals for future hospital-based services is necessary due to the termination of the contract between the health plan and the terminating hospital.
3. The date of the contract termination and redirection to alternate hospitals.
4. A statement that the affected Members may contact CalOptima Health's Customer Service Department to request completion of care for an ongoing course of treatment from a terminated Health Care Provider. This statement may include either:
 - a. A statement outlining the specific conditions set forth in Section 1373.96(c) (with each of the conditions specifically enumerated in bullet point format); or

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- b. An explanation to the affected Member that his or her eligibility is conditioned upon certain factors as outlined in the health plan's written continuity of care policy and evidence of coverage or disclosure form (with identification of the specific page(s) of the Member's health plan contract, policy, evidence of coverage, or disclosure form describing the specific conditions set forth in Section 1373.96(c)).
 - 5. The telephone number, clearly printed, through which affected Members may contact the health plan for a further explanation of the Member's rights to completion of care, including the health plan's written continuity of care policy.
 - 6. A link that an affected Member may use to obtain a downloadable copy of the health plan's written continuity of care policy from the health plan's website (which, at a minimum, shall direct the Member to the initial webpage where the Member may begin to access health plan documents [e.g., Member login page, health plan homepage with Member login, Member documents page, etc.]).
 - 7. If applicable, a statement informing any Member of a point of service product that the affected Member may be required to pay a larger portion of costs if he or she continues to use his or her current Health Care Providers.
 - 8. The following statement in at least 8-point font:
 - a. If you have been receiving care from a Health Care Provider, you may have a right to keep your Health Care Provider for a designated time period. Please contact CalOptima Health's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number 1-888-HMO-2219, or at a TTY number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov.
 - 9. Compliance with all applicable language assistance statutes and regulations, including Section 1367.04 and any regulations based upon Section 1367.04 (which, at a minimum, shall include a written notice of the availability of interpretation services in CalOptima Health's identified threshold languages and in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the DHCS).
- F. **Covered California:** CalOptima Health shall include the following information in the ETNs when there is a contract termination with a provider group, in addition to the requirements set forth in Section E (except E.1. to E.3.):
- 1. The name of the terminating provider group, and, where appropriate, the name of the assigned physician.
 - 2. A brief explanation as to why the reassignment to alternate receiving Health Care Providers or provider groups is necessary due to the termination of the contract between CalOptima Health and the Health Care Provider.
 - 3. The date of the contract termination and reassignment to alternate receiving Health Care Providers or provider groups.
 - 4. An explanation to the affected Member outlining:

- a. The affected Member's assignment to a new provider group, which, at a minimum, must briefly describe to the Member the reassignment process that occurs when CalOptima Health's contract with the Member's Health Care Provider terminates;
 - b. Options for selecting a physician within a new provider group; and,
 - c. Applicable timeframes to make a new provider group selection.
5. The explanation to the affected Member in Section II.F.4. must include a notification to the affected Member that he or she may select a different Network Provider by contacting CalOptima Health as outlined in CalOptima Health's written continuity of care policy and evidence of coverage or disclosure form.
 6. The name, address and telephone number of the receiving provider group and assigned physician within that group, or a statement that the plan will send the Member, by a date specified in the ETN, a new member information card containing this information.
- E.C.** Member notification for successfully renegotiated contracts with a Network Provider/Subcontractor prior to the effective date of contract termination where Member notices were already mailed out.
1. CalOptima Health's or a Health Network's written notice to affected Members shall include, at a minimum, the following information:
 - a. An explanation that an agreement has been reached with the Network Provider/Subcontractor;
 - b. An explanation of the Member's option to remain with, or change his or her PCP or Health Network;
 - c. Language providing the Member the Customer Service telephone number and the toll-free number of the DHCS Office of the Ombudsman; and
 - d. **Covered California:** All language required by HSC Section 1373.65.
- F. CalOptima Health shall take action pursuant to CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services, in response to the discovery or final notice from DHCS of a ~~provider~~Health Care Provider suspension, termination, or decertification.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. 2026 NCQA Health Plan Accreditation (HPA) Standards and Guidelines – Net 4: Continued Access to Care, Element A: Notification of Termination
- B. CalOptima Health Contract with Department of Health Care Services (DHCS)
- C. CalOptima Health Policy AA.1220: Member Billing
- ~~D. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process~~

- ~~E.D.~~ CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory
- ~~F.E.~~ CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination
- ~~G.F.~~ CalOptima Health Policy GG.1600: Access and Availability Standards
- ~~H.G.~~ CalOptima Health Policy GG.1607: Monitoring Adverse Actions
- ~~I.H.~~ CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
- ~~J.I.~~ Change of Location Template
- ~~K.J.~~ Community-Based Adult Services (CBAS) Center Closure Template
- ~~L.K.~~ Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network and Subcontractor Terminations (Supersedes APL 16-001)
- L. Department of Managed Health Care (DMHC) All Plan Letter (APL) 19-013: Block Transfer Member Transfer Notices
- M. Health and Safety Code, § 1373.65
- N. Long Term Care (LTC) Facility Closure Template
- O. Plan/Health Network Primary Care Provider (PCP) Change Template
- P. Plan/Health Network Specialist Change Template
- Q. Precluded Provider Template
- R. Title 22, California Code of Regulations (CCR), §§ 53885 and 53922.5
- S. Title 28, California Code of Regulations (CCR), § 1300.67(1)(3)
- T. Title 42, Code of Federal Regulations (CFR), §§ 438.10(f)(1), and 438.10(g)(4)
- U. Welfare and Institutions Code (WIC), §§ 14043.6 and 14123

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/04/2014	Department of Health Care Services (DHCS)	Approved as Submitted
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	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
05/07/2026	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2011	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	01/01/2013	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	04/01/2015	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	03/01/2016	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	03/01/2018	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2019	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	02/01/2020	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	12/01/2021	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	09/01/2022	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	11/01/2023	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
Revised	12/01/2024	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
Revised	12/01/2025	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
Revised	07/01/2026	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
<u>Revised</u>		<u>DD.2012</u>	<u>Member Notification of Change in Location or Availability of Providers or Covered Services</u>	<u>Medi-Cal & Covered California</u>

For 20261001 BOM

1 IX. GLOSSARY

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Term	Definition
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a health network; and 3. Ability to function as a Primary Care Provider (PCP).
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Contracted Hospital	A hospital that has entered into a CalOptima Health Hospital Services Contract to provide: 1. Hospital Services to CalOptima Health Direct Members for which CalOptima Health is financially responsible; and 2. Covered Services to Members Enrolled in a Shared Risk Group for which CalOptima Health is financially responsible in accordance with the Division of Financial Responsibility (DOFR).
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

Term	Definition
	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;

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 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. Covered California: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law. 17. Medi-Cal: Medi-Cal services for which [MCP] CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form)
<u>Health Care Provider</u>	<u>Any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.</u>
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), medical group or independent physician associations (IPA) that contracts with CalOptima Health to provide covered services to members assigned to that health network who may also qualify as a subcontractor.
Long Term Care (LTC) Facility	For purposes of this policy, a Skilled Nursing Facility (SNF) for Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B), Intermediate Care Facility/Developmentally Disabled, Intermediate Care Facility/Developmentally Disabled –Habilitative (ICF/DD-H), or Intermediate Care Facility/Developmentally Disabled-Nursing (ICF/DD-N).

Term	Definition
Medically Necessary or Medical Necessity	<u>Covered California: 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).</u> <u>Medi-Cal:</u> Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Network Provider	For purposes of this policy, a Provider that is contracted with CalOptima Health or a Health Network for the delivery of Medi-Cal Covered Services.
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.

Term	Definition
Subcontractor	<u>Covered California: An individual or entity that has an agreement with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's services under this Agreement. A provider is not a Subcontractor solely because it enters into a provider agreement.</u> <u>Medi-Cal:</u> An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

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For 20261001 BOD Review Only



Policy: DD.2012
Title: **Member Notification of Change in Location or Availability of Providers or Covered Services**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 11/01/2011

Revised Date:

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

I. PURPOSE

This policy defines the process by which CalOptima Health, or a Health Network, shall notify a Member of any change in location or availability of Health Care Providers or Covered Services.

II. POLICY

A. CalOptima Health or a Health Network shall ensure that Members are notified in a timely manner of any changes in the availability of Network Providers or location of Covered Services, as described in this Policy and in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network and Subcontractor Terminations and Department of Managed Health Care (DMHC) All Plan Letter 19-013: Block Transfer Member Transfer Notices, resulting from, but not limited to:

1. Changes in the hours, days, or location at which Covered Services are available; or
2. Termination, or non-renewal of a CalOptima Health or Health Network Provider's contract with CalOptima Health.
3. State or federal government suspension, or exclusion from participation in the Medicaid or Medicare program. Suspension or exclusion may occur when an individual or entity is:
 - a. Convicted of a felony;
 - b. Convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualification, functions, or duties of a provider of service;
 - c. Suspended from the Medicare or Medicaid programs for any reason; or
 - d. Lost or surrendered a license, certificate, or approval to provide care.

B. CalOptima Health shall be responsible for notifying Members of any changes to their assigned Primary Care Provider, as described in this Policy.

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- C. Health Networks shall be responsible for notifying Members enrolled with the respective Health Network of any changes to specialty care providers, as described in this Policy.
 - D. CalOptima Health or a Health Network shall provide written notice to all impacted Members informing them of the contract termination either thirty (30) calendar days prior to the effective date of the contract termination or fifteen (15) calendar days after receipt or issuance of the termination, whichever is later, unless directed by DHCS or DMHC.
 - E. If CalOptima Health or a Health Network is notified of a contract termination less than thirty (30) calendar days prior to the effective date of termination, CalOptima Health or a Health Network shall immediately notify all impacted Members of the termination.
 - F. For the California Department of Public Health (CDPH) Initiated Facility Decertification and Suspensions, CalOptima Health shall work with the facility to ensure that Members continue to receive Medically Necessary Covered Services and Member notices shall include the information outlined in Section III.D. of this Policy.
 - 1. If the facility is residential and remains open, Members shall have at least thirty (30) days post-notice to transition to a new facility, with the following exceptions:
 - a. The safety of a Member in a facility (e.g., skilled nursing facility (SNF)) is endangered;
 - b. The health of a Member in a facility is endangered;
 - c. A Member's health improves sufficiently so that the Member no longer requires the services provided by the facility;
 - d. A Member's urgent medical needs require an immediate transfer or discharge;
 - e. A Member has not resided in a facility for thirty (30) days or more;
 - f. A Member, their guardian, conservator, or Authorized Representative has requested a transition to another facility; or
 - g. A facility closes or is no longer operational.
 - G. In the event of a natural disaster or emergency, CalOptima Health or a Health Network shall notify Members of any changes in the availability or location of Covered Services, as soon as possible, and within fourteen (14) calendar days of the change.
 - H. In the case of unforeseen circumstances, (i.e., if CalOptima Health or a Health Network receives inadequate notice of a change in the Network Provider contract status and is unable to notify Members in writing at least thirty (30) calendar days prior to the effective date of the termination), CalOptima Health or a Health Network shall notify Members of the change within fifteen (15) calendar days after receipt or issuance of the termination notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated Network Provider.
 - I. Member notices shall include the information as outlined in Sections III.C. and III.D of this Policy.
 - J. If a contract is successfully renegotiated with a CalOptima Health Network Provider before the effective date of the contract termination, and Member notices have already been mailed,

CalOptima Health shall mail another notice to inform Members that the contract is not being terminated. CalOptima Health may submit a template notice for DHCS approval and must include information as described in Section III.E. of this Policy.

- K. CalOptima Health or a Health Network shall notify Members in writing of any changes in the availability or location of Covered Services, Health Care Providers, or any other changes in information, at least thirty (30) calendar days prior to the effective date of such changes, unless otherwise specified in this Policy.
1. CalOptima Health shall obtain approval from DHCS prior to making any substantial change in the availability or location of Covered Services, including, but not limited to, any proposal to reduce or change the hours, days, or location at which the services are available in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.
 2. CalOptima Health may use a template notice previously approved by DHCS if no changes were made. If CalOptima Health makes a change to a DHCS-approved template, or does not have an approved template on file, the notice must be submitted to DHCS for review and approval prior to mailing to Members.
- L. For Network Provider terminations affecting two thousand (2,000) or more Members, or if there are Members who cannot be reassigned to a PCP within required time and/or distance standards as described in CalOptima Health Policy GG.1600: Access and Availability Standards, CalOptima Health shall submit the written Member notice as well as a narrative or transition plan of how CalOptima Health shall intend to provide Covered Services to affected Members at least sixty (60) calendar days prior to the expected date of termination to DHCS for review and approval in accordance with this policy and CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.
- M. For Network Provider terminations affecting fewer than two thousand (2,000) Members, CalOptima Health can reassign all affected Members to a Network Provider, as applicable, within required time as distance standards as described in CalOptima Health Policy GG.1600: Access and Availability Standards, CalOptima Health may send the written Member notification that was previously reviewed and approved by DHCS.
- N. A Health Network shall notify CalOptima Health of a change in the availability or location of Covered Services; a termination of a Network Provider, including but may not be limited to, PCP, Community Health Center, contracted Health Network, IPA, medical group or hospital contract; or any other changes in information, in accordance with this Policy and CalOptima Health Policies EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory and GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.
1. For Network Provider, including but may not be limited to, PCP, Community Health Center, IPA or medical group terminations, a Health Network must submit the written Member notices to the CalOptima Health, Health Network Relations Department at least ninety (90) calendar days in advance of the intended date of distribution to Members, unless the notice is for PCP and Community Clinic terminations as described in Section II.K. of this Policy and is already approved by DHCS;

- 1 2. For contracted hospital terminations, a Health Network must submit the written Member notices
2 to the CalOptima Health, Health Network Relations Department at least sixty (60) calendar days
3 prior to the expected date of termination; and
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- 5 3. If a written Member notice has not been approved by DHCS, CalOptima Health shall obtain
6 approval prior to its release to Members.
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- 8 O. DHCS will notify CalOptima Health of any Medi-Cal Health Care Providers that have been
9 suspended, terminated, or decertified from participating in the Medi-Cal program. CalOptima
10 Health or a Health Network shall take action pursuant to Section III.F of this Policy.
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- 12 1. In the case of an immediate closure by the California Department of Public Health (CDPH),
13 CDPH is responsible for the transition of affected Members. CalOptima Health or a Health
14 Network shall track the transition of these Members and coordinate care, as needed.
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- 16 P. CalOptima Health may modify the notification period identified in this Policy if it deems it to be in
17 the best interest of the Member, CalOptima Health, or a Health Network.
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- 19 Q. CalOptima Health or a Health Network shall ensure continuity of care during Network Provider
20 terminations, or in the event the Member is required to change Health Networks, due to a Health
21 Network participation status in the CalOptima Health Medi-Cal program in accordance with
22 CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider
23 Termination.
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- 25 R. **Covered California:** CalOptima Health shall submit their Block Transfer Filings to DMHC for
26 review. The filing must include an example or “template” of the written Member Transfer Notice
27 (ETN) CalOptima Health intends to send to affected Members regarding the date of the contract
28 termination and reassignment (or redirection) to a new provider group (or hospital). The DMHC
29 reviews the template ETNs to ensure the documents include all information required by law. In
30 addition, California Code of Regulations, Title 22, Sections 53852 and 53911 require Medi-Cal
31 managed care health plans to obtain written approval from the Department of Health Care Services
32 (DHCS) prior to making any substantial change in the availability or location of Covered Services.
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34 III. PROCEDURE

35 A. Health Network Notification to CalOptima Health

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- 38 1. A Health Network shall notify the CalOptima Health, Provider Relations Department of a
39 change in the availability or location of Covered Services, or a termination of a Network
40 Provider and/or Subcontractor.
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- 42 2. A Health Network shall submit written Member notices to the CalOptima Health, Health
43 Network Relations Department for review prior to distribution to Members in accordance with
44 Section II.O. of this Policy.
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- 46 a. The CalOptima Health, Health Network Relations Department shall submit written Member
47 notices to the CalOptima Health Regulatory Affairs & Compliance Department for
48 submission to DHCS prior to distribution to Members. Upon receipt of the response from
49 DHCS, the CalOptima Health Regulatory Affairs & Compliance Department shall notify
50 the CalOptima Health, Health Network Relations Department.
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- 1 b. A Health Network shall be responsible for notifying Members pursuant to the specified
2 timelines detailed in this policy. A Health Network shall notify the CalOptima Health,
3 Health Network Relations Department of the date of the mailings and the number of
4 Members receiving the written notification.
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- 6 3. A Health Network shall submit a narrative or transition plan to the CalOptima Health, Health
7 Network Relations Department detailing how the Health Network intends to continue to provide
8 Covered Services to affected Members. This narrative or transition plan shall be submitted to
9 DHCS by CalOptima Health in accordance with CalOptima Health Policy GG.1652: DHCS
10 Notification of Change in the Availability or Location of Covered Services.
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- 12 B. The CalOptima Health Contracting Department or Provider Relations Department shall notify
13 CalOptima Health Customer Service Department of a change in the availability or location of
14 Covered Services for Health Network Providers, in accordance with this Policy.
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- 16 1. The CalOptima Health Customer Service Department shall submit written Member notices to
17 the CalOptima Health Regulatory Affairs & Compliance Department for submission to DHCS
18 prior to distribution to Members in accordance with this Policy. Upon receipt of the response
19 from DHCS, the CalOptima Health Regulatory Affairs & Compliance Department shall notify
20 the CalOptima Health Customer Service Department.
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- 22 2. The CalOptima Health Case Management, Long Term Services and Supports (LTSS) or Health
23 Network Relations Departments shall submit the narrative description or transition plan of how
24 CalOptima Health or a Health Network shall intend to provide Covered Services to affected
25 Members in accordance with CalOptima Health Policy GG.1652: DHCS Notification of Change
26 in the Availability or Location of Covered Services.
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- 28 C. **Medi-Cal:** Member notification for termination of a Network Provider, including a PCP,
29 Community Health Center, Health Network, IPA, medical group, or hospital:
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- 31 1. CalOptima Health's or the Health Network's written notice to Members shall include, at a
32 minimum, the following:
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- 34 a. Effective date of the contract termination;
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- 36 b. A description of how the contract termination will impact the Member's access to Covered
37 Services, if applicable;
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- 39 c. Name of the terminating/terminated Network Provider/Subcontractor;
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- 41 d. Name of the new Network Provider/Subcontractor that the Member is being assigned to, if
42 applicable;
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- 44 e. Member rights information on how to request a new Health Care Provider if the Member
45 elects to change from the Health Care Provider CalOptima Health reassigned them to;
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- 47 f. If applicable, the name of another hospital the Member will be assigned to or can access in
48 the service area;
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- 50 g. All language required by Health and Safety Code (HSC) Section 1373.65, including the
51 Member's Continuity of Care (COC) rights to the terminating/terminated Network

Provider/Subcontractor, unless the Network Provider/Subcontractor has been excluded from participating in the Medi-Cal Program; and

h. Language providing the Member with CalOptima Health or Health Network Customer Services telephone number and the toll-free telephone number of DHCS' Office of the Ombudsman.

2. CalOptima Health's Customer Service Department, with the assistance of other operational departments, as needed, will assist the Member in selecting a new PCP or Health Care Provider, upon request.

D. Upon discovery of a Long-Term Care (LTC) Facility decertification or suspension, CalOptima Health shall terminate its contract with the facility, and provide notice to all impacted Members within five (5) calendar days of receiving notification of the closure or effective date of the termination, and at a minimum must include the following information:

1. Effective date of the contract termination;
2. The name of the LTC Facility;
3. The reason for the decertification;
4. A description of how the decertification will impact the Member's access to covered services;
5. All language required by HSC Section 1373.65;
6. Language providing the member with CalOptima Health's Member Services telephone number and the toll-free telephone number of DHCS' Office of the Ombudsman for questions or concerns;
7. A description of how the CalOptima Health will maintain the ability to provide covered services to impacted Members; and
8. The date the member notice will be mailed.

E. **Covered California:** CalOptima Health shall include the following information in the ETNs when there is a contract termination with a general acute care hospital:

1. The name of the terminating general acute hospital.
2. A brief explanation as to why the redirection to alternate hospitals for future hospital-based services is necessary due to the termination of the contract between the health plan and the terminating hospital.
3. The date of the contract termination and redirection to alternate hospitals.
4. A statement that the affected Members may contact CalOptima Health's Customer Service Department to request completion of care for an ongoing course of treatment from a terminated Health Care Provider. This statement may include either:
 - a. A statement outlining the specific conditions set forth in Section 1373.96(c) (with each of the conditions specifically enumerated in bullet point format); or

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- b. An explanation to the affected Member that his or her eligibility is conditioned upon certain factors as outlined in the health plan's written continuity of care policy and evidence of coverage or disclosure form (with identification of the specific page(s) of the Member's health plan contract, policy, evidence of coverage, or disclosure form describing the specific conditions set forth in Section 1373.96(c)).
 - 5. The telephone number, clearly printed, through which affected Members may contact the health plan for a further explanation of the Member's rights to completion of care, including the health plan's written continuity of care policy.
 - 6. A link that an affected Member may use to obtain a downloadable copy of the health plan's written continuity of care policy from the health plan's website (which, at a minimum, shall direct the Member to the initial webpage where the Member may begin to access health plan documents [e.g., Member login page, health plan homepage with Member login, Member documents page, etc.]).
 - 7. If applicable, a statement informing any Member of a point of service product that the affected Member may be required to pay a larger portion of costs if he or she continues to use his or her current Health Care Providers.
 - 8. The following statement in at least 8-point font:
 - a. If you have been receiving care from a Health Care Provider, you may have a right to keep your Health Care Provider for a designated time period. Please contact CalOptima Health's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number 1-888-HMO-2219, or at a TTY number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.ca.gov.
 - 9. Compliance with all applicable language assistance statutes and regulations, including Section 1367.04 and any regulations based upon Section 1367.04 (which, at a minimum, shall include a written notice of the availability of interpretation services in CalOptima Health's identified threshold languages and in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the DHCS).
- F. **Covered California:** CalOptima Health shall include the following information in the ETNs when there is a contract termination with a provider group, in addition to the requirements set forth in Section E (except E.1. to E.3.):
- 1. The name of the terminating provider group, and, where appropriate, the name of the assigned physician.
 - 2. A brief explanation as to why the reassignment to alternate receiving Health Care Providers or provider groups is necessary due to the termination of the contract between CalOptima Health and the Health Care Provider.
 - 3. The date of the contract termination and reassignment to alternate receiving Health Care Providers or provider groups.
 - 4. An explanation to the affected Member outlining:

- a. The affected Member's assignment to a new provider group, which, at a minimum, must briefly describe to the Member the reassignment process that occurs when CalOptima Health's contract with the Member's Health Care Provider terminates;
 - b. Options for selecting a physician within a new provider group; and,
 - c. Applicable timeframes to make a new provider group selection.
5. The explanation to the affected Member in Section II.F.4. must include a notification to the affected Member that he or she may select a different Network Provider by contacting CalOptima Health as outlined in CalOptima Health's written continuity of care policy and evidence of coverage or disclosure form.
 6. The name, address and telephone number of the receiving provider group and assigned physician within that group, or a statement that the plan will send the Member, by a date specified in the ETN, a new member information card containing this information.
- C. Member notification for successfully renegotiated contracts with a Network Provider/Subcontractor prior to the effective date of contract termination where Member notices were already mailed out.
1. CalOptima Health's or a Health Network's written notice to affected Members shall include, at a minimum, the following information:
 - a. An explanation that an agreement has been reached with the Network Provider/Subcontractor;
 - b. An explanation of the Member's option to remain with, or change his or her PCP or Health Network;
 - c. Language providing the Member the Customer Service telephone number and the toll-free number of the DHCS Office of the Ombudsman; and
 - d. **Covered California:** All language required by HSC Section 1373.65.
- F. CalOptima Health shall take action pursuant to CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services, in response to the discovery or final notice from DHCS of a Health Care Provider suspension, termination, or decertification.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. 2026 NCQA Health Plan Accreditation (HPA) Standards and Guidelines – Net 4: Continued Access to Care, Element A: Notification of Termination
- B. CalOptima Health Contract with Department of Health Care Services (DHCS)
- C. CalOptima Health Policy AA.1220: Member Billing
- D. CalOptima Health Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory

- E. CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination
- F. CalOptima Health Policy GG.1600: Access and Availability Standards
- G. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
- H. CalOptima Health Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
- I. Change of Location Template
- J. Community-Based Adult Services (CBAS) Center Closure Template
- K. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network and Subcontractor Terminations (Supersedes APL 16-001)
- L. Department of Managed Health Care (DMHC) All Plan Letter (APL) 19-013: Block Transfer Member Transfer Notices
- M. Health and Safety Code, § 1373.65
- N. Long Term Care (LTC) Facility Closure Template
- O. Plan/Health Network Primary Care Provider (PCP) Change Template
- P. Plan/Health Network Specialist Change Template
- Q. Precluded Provider Template
- R. Title 22, California Code of Regulations (CCR), §§ 53885 and 53922.5
- S. Title 28, California Code of Regulations (CCR), § 1300.67(1)(3)
- T. Title 42, Code of Federal Regulations (CFR), §§ 438.10(f)(1), and 438.10(g)(4)
- U. Welfare and Institutions Code (WIC), §§ 14043.6 and 14123

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/04/2014	Department of Health Care Services (DHCS)	Approved as Submitted
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
07/26/2021	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
05/07/2026	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2011	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	01/01/2013	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	04/01/2015	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	03/01/2016	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	03/01/2018	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	02/01/2019	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2020	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	12/01/2021	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	09/01/2022	DD.2012	Member Notification of Change in the Availability or Location of Covered Services	Medi-Cal
Revised	11/01/2023	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
Revised	12/01/2024	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
Revised	12/01/2025	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
Revised	07/01/2026	DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal
Revised		DD.2012	Member Notification of Change in Location or Availability of Providers or Covered Services	Medi-Cal & Covered California

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1 IX. GLOSSARY

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Term	Definition
Authorized Representative	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a health network; and 3. Ability to function as a Primary Care Provider (PCP).
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Contracted Hospital	A hospital that has entered into a CalOptima Health Hospital Services Contract to provide: 1. Hospital Services to CalOptima Health Direct Members for which CalOptima Health is financially responsible; and 2. Covered Services to Members Enrolled in a Shared Risk Group for which CalOptima Health is financially responsible in accordance with the Division of Financial Responsibility (DOFR).
Covered Services	Covered California: Medically Necessary services and supplies that CalOptima Health Covered Members are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law. Medi-Cal: Medi-Cal services for which [MCP]CalOptima Health is responsible for payment. Covered services are subject to the terms, conditions, limitations, and exclusions of the Medi-Cal contract, any contract amendment, and as listed in this Member Handbook (also known as the Combined Evidence of Coverage (EOC) and Disclosure Form)
Health Care Provider	Any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), medical group or independent physician associations (IPA) that contracts with CalOptima Health to provide covered services to members assigned to that health network who may also qualify as a subcontractor.

Term	Definition
Long Term Care (LTC) Facility	For purposes of this policy, a Skilled Nursing Facility (SNF) for Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B), Intermediate Care Facility/Developmentally Disabled, Intermediate Care Facility/Developmentally Disabled –Habilitative (ICF/DD-H), or Intermediate Care Facility/Developmentally Disabled-Nursing (ICF/DD-N).
Medically Necessary or Medical Necessity	<u>Covered California</u>: 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). <u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Network Provider	For purposes of this policy, a Provider that is contracted with CalOptima Health or a Health Network for the delivery of Medi-Cal Covered Services.

Term	Definition
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.
Subcontractor	<u>Covered California</u>: An individual or entity that has an agreement with CalOptima Health that relates directly or indirectly to the performance of CalOptima Health's services under this Agreement. A provider is not a Subcontractor solely because it enters into a provider agreement. <u>Medi-Cal</u>: An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

1

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Approve CalOptima Health Network Management Policies Related to Covered California

Contact

Michael Gomez, Executive Director, Network Management, (714) 347-3292

Recommended Action

Approve health network management policies and procedures to reflect new operational requirements for CalOptima Health's Covered California product, effective November 1, 2026:

1. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment

Background

Over the past two years, CalOptima Health has made significant progress preparing for entrance into the Covered California program. The CalOptima Health Board of Directors (Board) has taken several actions related to Covered California. On August 1, 2024, the CalOptima Health Board authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California.

On August 6, 2026, the Board authorized CalOptima Health to execute the Qualified Health Plan contract with Covered California. On August 11, 2026, CalOptima Health received conditional approval from the Department of Managed Health Care (DMHC) to expand the scope of its current Knox-Keene Act license to enable CalOptima Health to offer the Covered California product.

Discussion

On June 5, 2025, the Board approved several CalOptima Health policies related to regulatory requirements for Covered California as part of the DMHC filing process. The process required the

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

In addition to regulatory policies approved by DMHC, staff evaluated several operational policies and procedures determining that a policy change or update was necessary to address operational changes for CalOptima Health's Covered California product. While these policy updates do not require DMHC approval currently, they are required to support the implementation of CalOptima Health's Covered California product.

In the area of network management, staff recommends approval of an update to the auto-assignment policy for Covered California members.

Policies & Procedures Summary – Network Management

<i>Policy</i>	<i>Summary of Change/Update</i>
CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment	Updated policy to add auto-assignment processes for Covered California members. 1. New members entering CalOptima Health's network that do not have a prior Primary Care Provider (PCP) or Health Network (HN), the auto-assignment process will apply, as specified by CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment. 2. Once the member goes through auto-assignment process and wants to select a new PCP or HN, the member selection process will apply, as specified by CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network Selection/Assignment.

Staff seeks Board approval of the attached revised policy, effective November 1, 2026.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what is included in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

Approval of updated and new operational policies and procedures will support CalOptima Health's operational implementation of the Covered California program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. [CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment](#)



Policy: AA.1207a
Title: **CalOptima Health Auto-Assignment**
Department: Provider Network Operations
Section: Provider Data Operations

CEO Approval: /s/

Effective Date: 01/01/2007

Revised Date:

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

I. PURPOSE

This policy establishes a process by which CalOptima Health assigns a Member to a Health Network or CalOptima Health Community Network (CHCN), and a Primary Care Provider (PCP).

II. POLICY

A. Upon eligibility with CalOptima Health, CalOptima Health shall assign Members to a Health Network and PCP in accordance with the terms and conditions of this policy. to ensure the following:

~~B. CalOptima Health shall Auto Assign Members, in accordance with the provisions of this policy, to ensure the following:~~

1. Member access to health care services within required time and distance standards to their residence, as on file with CalOptima Health from eligibility files received from the Department of Health Care Services (DHCS); for the Medi-Cal Program and Covered California for the CalOptima Health Covered program.
2. Community Health Center safety net provider participation in the ~~CalOptima Health~~ Medi-Cal program; and
3. Member enrollment in Health Networks or CHCN (for the Medi-Cal program) demonstrating quality performance.

~~B. CalOptima Health shall process eligibility and enrollment data received from the Department of Health Care Services (DHCS) and Covered California and assign a PCP and Health Network to each Member based on the following:~~

1. Previously assigned PCP and Health Network: If a Member is a returning Member to CalOptima Health and Member's previously assigned PCP and Health Network are active with CalOptima Health, Member shall be reassigned to the same PCP and Health Network to maintain continuity of care.
2. Family Links: For a Member where CalOptima Health system identifies a family member currently assigned to a PCP and Health Network, CalOptima Health will assign the Member to

the same PCP and Health Network as the family member(s) provided the provider's specialty type is appropriate for the Member's age and gender.

3. Whole Child Model: Members who are eligible for the Whole Child Model program, where the Member requires assignment to a PCP and/or Health Network with specific certifications, specialties and coverage.
4. Auto Assignment: Members who have not been assigned a PCP and/or Health Network through the above mechanism are assigned a PCP, Community Health Center, and/or Health Network through the CalOptima Auto-Assignment processes. The Auto-Assignment process shall identify the best match for a Member based on:
 - a. Geographic proximity to the Member's residence and within the maximum travel distance standards specified by DHCS for Medi-Cal and DMHC for Covered California;
 - b. Age;
 - c. Gender;
 - d. Community Health Center Quality Rating (applicable to Medi-Cal Only);
 - e. Health Network Quality Rating; and
 - f. PCP and Health Network capacity.

C. Members may request to change their Health Network ~~and/or CHCN enrollment and PCP once per month~~ at any time, in accordance with CalOptima Health Policy DD. ~~2008-2006b: Member Primary Care Provider and Health Network and CalOptima Health Community Network Selection Process/Assignment.~~

D. ~~CalOptima Health shall Auto Assign a Member to a Health Network or CHCN by using available data from CalOptima Health or network providers or clinics indicating an existing relationship with a contracted provider or clinic to preserve the relationship where possible. In the absence of this information, the Auto Assign of a Member is based on a Zip Code Match between the Member's residence and a Health Network/CHCN, and PCP coverage area, as set forth in Section III.A.2.b. of this policy.~~

III.I. PROCEDURE

A. ~~CalOptima Health shall Auto Assign eligible Members to a Health Network or CHCN as follows, and in the following order:~~

For the Medi-Cal Program,

1. ~~CalOptima Health shall Auto Assign a Member to an existing contracted provider or clinic when provided with the data establishing the relationship by CalOptima Health or a network provider or clinic.~~

2.D. CalOptima Health shall Auto-Assign no less than thirty-seven percent (37%) of eligible Members to a Health Network or CHCN based on the Member's assignment to ~~an eligible~~ community health center as a Primary Care Provider (PCP). CalOptima Health shall Auto-Assign Members through the Health Network or CHCN level to the Community Health Center. If a new Federally Qualified Health Center (FQHC), or FQHC-Look-Alike, enters the CalOptima Health

1 program, CalOptima Health shall increase the base Auto-Assignment allocation for Community
2 Health Centers by one percent (1%), not to exceed forty-five percent (45%). If ~~ana~~ FQHC, or
3 FQHC-Look-Alike, terminates with the CalOptima Health program, CalOptima Health shall
4 decrease the total Auto-Assignment allocation by one percent (1%), not to fall below thirty-seven
5 percent (37%).

6 III. PROCEDURE

7
8
9
10 A. Medi-Cal: CalOptima Health shall Auto-Assign eligible Members to a. ~~_____~~ A Health Network or
11 CHCN as follows, and in the following order:

12
13 1. CalOptima Health shall Auto-Assign a Member to an existing contracted primary care physician
14 or a Community Health Center as the PCP.

15
16 a. A Member who loses and regains eligibility with CalOptima Health within a twelve (12)
17 month period shall be assigned to the most recent Health Network and PCP assigned to the
18 Member, willing to accept new and existing patients.

19
20 b. Should the Member's previous PCP no longer participate in the CalOptima program, a new
21 PCP shall be assigned, maintaining the member assignment to the previous Health Network.

22
23 c. Should the Member's previous health network not participate in the member's current
24 program at CalOptima Health and member's previous PCP is active with another
25 CalOptima Health Network for the same program, CalOptima Health shall maintain the
26 member's assignment to the previous PCP and assign Member to the PCP's participating
27 Health Network.

28
29 d. Should a Member's previous PCP and Health Network not participate in the Member's
30 respective CalOptima program, the Member will be auto-assigned to a participating Health
31 Network and PCP.

32
33 2. In an effort to keep Members of the same family covered under one (1) Health Network or
34 CHCN, and where possible, one PCP, CalOptima Health shall Auto-Assign Members by family
35 unit in accordance with CalOptima Health Policy DD.2006b: CalOptima Health Community
36 Network Member Primary Care Provider Selection/Assignment. If a Family Linked Member
37 who is less than twenty-one (21) years of age has family members in more than one (1) Health
38 Network or CHCN, CalOptima Health shall Auto-Assign such Family Linked Member to the
39 same Health Network or CHCN as his or her sibling.

40
41 3. For the Whole-Child Model (WCM) Program/California Children Services Program (CCS),
42 CalOptima shall assign Members in accordance with the following:

43
44 a. If the Family Linked Member is known to be eligible with the Whole-Child Model (WCM)
45 program/California Children Services Program (CCS) and the Family Linked Member's
46 sibling is assigned to a Health Network that does not participate in the WCM program
47 whether excluded from doing so or otherwise, the Family Linked Member shall be assigned
48 to a Health Network participating in the WCM program.

49
50 b. Notwithstanding any other provisions of this policy, CalOptima Health shall ensure,
51 effective July 1, 2019, that CCS-eligible Members are not assigned, whether by Auto-
52 Assignment or otherwise, to a Health Network that is excluded from participating in the
53 WCM program.

1 c. An existing Member assigned to a Health Network who becomes CCS/WCM-eligible, or a
2 new CCS/WCM Member, will be assigned to a participating Health Networks after
3 consideration of factors, unique to each Member, such as current PCP and specialist
4 relationships to the Member, Member's preference, provider and service utilization,
5 diagnosis, severity of condition, Health Needs Assessment, geography, and language.

6
7 d. If a new Member who is known to be CCS-eligible or an existing Member who becomes
8 CCS-eligible (while enrolled in a Health network that does not participate in the WCM
9 program) CalOptima Health's Auto-Assignment process will only allow a new CalOptima
10 Health Member who is known to be CCS-eligible, to be assigned to a participating Health
11 Network. All other existing Auto-Assignment rules will apply, including accounting for
12 allotted percentages for the Health Networks.

13
14 e. A Health Network that does not meet the WCM network certification requirements can
15 become eligible for the WCM category of Auto-Assignment if the Health Network meets
16 such requirements at a later date and is added to the WCM network with the approval of
17 DHCS.

18
19 4. Notwithstanding any other provisions of this policy and if applicable, CalOptima Health shall
20 assign a new Health Network-eligible Member to CHOC Health Alliance if:

21
22 a. The Member will be less than seven (7) months of age at the time of enrollment with
23 CalOptima Health;

24
25 b. The Member does not have another Family Linked Member enrolled in a Health
26 Network/CHCN at the time of assignment; and

27
28 c. CHOC Health Alliance is not suspended from Auto-Assignment.

29
30 5. CalOptima Health shall allocate percentages of the remaining auto-assignment eligible Medi-
31 Cal Members to the Community Health Centers and Health Networks based on annual
32 qualifications and quality ratings outlined in Policies AA.1207b: Performance-based Health
33 Network and CalOptima Health Community Network Auto-Assignment Allocation
34 Methodology and Policy AA.1207c: Performance-based Community Health Center Auto-
35 Assignment Allocation Methodology.

36
37 6. CalOptima shall assign Members to individual Community Health Centers as the Member's
38 Primary Care Provider based on the Member's zip code match with a Community Health
39 Center's coverage. Members assigned to a Community Health Center shall be assigned to the
40 Health Network the Community Health Center has selected as the Health Network through
41 which they will receive their auto-assigned Members. CalOptima Health's auto-assignment to
42 the Community Health Centers shall maintain true for the following conditions and
43 requirements:

44
45 a. If CalOptima Health auto-assigns a Member to a Community Health Center as the
46 Member's PCP, the Member's Health Network or CHCN shall not reassign such Member to
47 a PCP that is not a Community Health Center unless the Member requests such
48 reassignment.

49
50 b. A Health Network or CHCN's receipt of Auto-Assigned Members from a Community
51 Health Center shall not affect the Health Network or CHCN's receipt of any other Auto-
52 Assigned Members.

1 ~~shall~~ Eligible Community Health Center shall annually submit an Auto-Assignment

2 Participation form, select CHCN or at least one (1) Health Network that shall receive its
3 allocation of Auto-Assigned Members. A Community Health Center may select CHCN or
4 one (1) Health Network that shall receive its allocation of pediatric Auto-Assigned
5 Members, and CHCN or one (1) Health Network that shall receive its allocation of adult
6 Auto-Assigned Members.
7

8 ~~i.c.~~ If a Community Health Center intends to select or unselect CHCN or change the Health
9 Network which shall receive its allocation of Auto-Assigned Members, it shall notify
10 CalOptima Health's Provider Relations Department, in writing.
11

12 ~~ii.d.~~ If a Community Health Center fails to select CHCN or at least one (1) Health Network that
13 shall receive its allocation of Auto-Assigned Members, CalOptima Health shall exclude that
14 Community Health Center from receiving any allocation of Auto-Assigned Members until a
15 Health Network, or CHCN, has been selected.
16

17 ~~iii.e.~~ If the Community Health Center previously selected CHCN or a Health Network that
18 has been suspended for Auto-Assignment, the Community Health Center shall select an
19 alternate Health Network or CHCN to receive its allocation of Auto-Assigned Members.
20

21 ~~b.~~ If a Member has a Zip Code Match with a Community Health Center's coverage area,
22 CalOptima Health shall assign the Member to the Community Health Center as the
23 Member's PCP.
24

25 ~~e.~~ CalOptima Health shall Auto Assign Members to Community Health Centers based on
26 performance metrics established in CalOptima Health Policy AA.1207c: Performance-based
27 Community Health Center Auto-Assignment Allocation Methodology.
28

29 ~~d.a.~~ A Health Network or CHCN's receipt of Auto-Assigned Members from a Community
30 Health Center shall not affect the Health Network or CHCN's receipt of any other Auto-
31 Assigned Members.
32

33 ~~e.~~ If CalOptima Health Auto Assigns a Member to a Community Health Center as the
34 Member's PCP, the Member's Health Network or CHCN shall not reassign such Member to
35 a PCP that is not a Community Health Center unless the Member requests such
36 reassignment.
37

38 ~~3.~~ CalOptima Health shall Auto Assign remaining Health Network eligible Members to a Health
39 Network or CHCN.
40

41 ~~a.~~ CalOptima Health shall assign Members to a Health Network or CHCN once it fills a
42 Community Health Center's assignment allocation, or if there is no Zip Code Match
43 between an eligible Member and a community health center's coverage area.
44

45 ~~b.7.~~ CalOptima Health shall Auto-Assign eligible Members to a Health Network or CHCN based on
46 the Health Network or CHCN's score on the indicators listed in the Health Network or CHCN
47 Performance-based Auto Assignment Allocation Table, which shall be calculated pursuant to
48 CalOptima Health Policy AA.1207b: Performance-based Health Network and CalOptima
49 Health Community Network Auto-Assignment Allocation Methodology.
50

51 ~~e.8.~~ CalOptima Health shall assign any remaining Members to a Health Network with a Zip Code
52 Match, regardless of whether ~~or not~~ that Health Network's Auto-Assignment allocation has
53 been satisfied.
54

1 ~~d.9.~~ Effective July 1, 2026, CalOptima Health shall auto-assign Members to PCPs within each
2 Health Network in accordance with the criteria set forth below:
3

4 ~~i.a.~~ Family Linked Members in the same household will be assigned to the same PCP or
5 medical group where possible;
6

7 ~~ii.b.~~ The PCP is within ten (10) miles of the Member's residence;
8

9 ~~iii.c.~~ The PCP does not have an age range or gender restriction that applies to the Member;
10

11 ~~iv.d.~~ The PCP is accepting new Members at the time of assignment;
12

13 ~~v.e.~~ Member age falls within the practice age range of PCP types as follows:
14

15 ~~a)i.~~ Family Medicine Providers and General Practice Providers: Auto-~~assign~~assignment
16 allowed for Members age zero (0) and up.
17

18 ~~b)ii.~~ Pediatricians: Auto-~~assign~~assignment allowed for Members up to age twenty-
19 one (21).
20

21 ~~e)iii.~~ Internal Medicine Providers: Auto-~~assign~~assignment allowed for Members
22 eighteen (18) years of age and older.
23

24 ~~e.10.~~ CalOptima Health will not auto-assign Members to Obstetricians/Gynecologists
25 (OB/GYN). Members may call in to request assignment to an OB/GYN if the provider has
26 elected to serve as a PCP.
27

28 ~~f.11.~~ The number of Auto-Assigned Members a Health Network or CHCN and PCPs receive
29 may vary monthly, depending upon the number of Members eligible for Auto-Assignment and
30 the Zip Code Match between a Member and a Health Network or CHCN's coverage area or the
31 PCP's coverage area.
32

33 ~~g.1.~~ In an effort to keep Members of the same family covered under one (1) Health Network or
34 CHCN, CalOptima Health shall Auto Assign Members by family unit in accordance with
35 CalOptima Health Policy DD.2006b: Member Primary Care Provider Selection/Assignment. If
36 a Family Linked Member who is less than twenty one (21) years of age has family members in
37 more than one (1) Health Network or CHCN, CalOptima Health shall Auto Assign such Family
38 Linked Member to the same Health Network or CHCN as his or her sibling.
39

40 ~~h.a.~~ If the Family Linked Member is known to be eligible with the Whole Child Model (WCM)
41 program/California Children Services Program (CCS) and the Family Linked Member's
42 sibling is assigned to a Health Network that does not participate in the WCM program
43 whether excluded from doing so or otherwise, the Family Linked Member shall be assigned
44 to a Health Network participating in the WCM program.
45

46 ~~i.~~ Notwithstanding any other provisions of this policy and if applicable, subject to Section
47 III.I., Covered California: CalOptima Health shall assign a new Auto-Assign CalOptima
48 Health Covered Members to a Health Network ~~eligible Member to CHOC Health Alliance~~
49 if:
50

51 ~~i.B.~~ The Member will be less than seven (7) months of age at and PCP according to the time of
52 enrollment with a Health Network or CHCN; following provisions:
53

~~ii.a. The Member does not have another Family Linked Member enrolled in a Health Network/CHCN at the time of assignment; and~~

~~iii. CHOC Health Alliance is not suspended from Auto Assignment pursuant to this policy.~~

~~Notwithstanding any other provisions of this policy, CalOptima Health shall ensure, effective July 1, 2019, that CCS-eligible Members are not assigned, whether by Auto Assignment or otherwise, to a Health Network that is excluded from participating in the WCM program.~~

~~j. CalOptima Health shall Auto-Assign a Member to an~~

- ~~1. An existing Member assigned contracted provider or clinic when provided with the data establishing the relationship by CalOptima Health or a network provider or clinic as outlined in the Medi-Cal Procedure Section III.A.1.~~
- ~~2. A Member who is new to CalOptima Health Covered and has a family member with a CalOptima Health program shall be assigned to the same provider, to ensure unity of family within one Health Network and where possible, one PCP in accordance with Medi-Cal Procedure Section III.A.2~~
- ~~3. A Members who is new to CalOptima Health Covered and has no family linkages within a CalOptima Health Program shall be assigned to a Health Network and PCP.~~
- ~~4. CalOptima Health shall allocate auto-assignment to a Health Network who becomes CCS/WCM-eligible, or new CCS/WCM Members, based on annual qualifications and quality ratings according to policy AA.1207b - Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology.~~
- ~~5. Each Member assigned to a Health Network shall be assigned a PCP in accordance with the criteria set forth below:~~
 - ~~a. Family members in the same household will be assigned to participating Health Networks after consideration of factors, unique to each Member, such as current PCP and specialist relationships; the same PCP or Community Health Center where possible;~~
 - ~~b. The PCP is within fifteen (15) miles of the Member's residence;~~
 - ~~c. The PCP does not have an age range or gender restriction that applies to the Member;~~
 - ~~d. The PCP is accepting new Members at the time of assignment;~~
 - ~~e. Member age falls within the practice age range of PCP types as follows:~~
 - ~~i. Family Medicine Providers and General Practice Providers: Auto-assignment allowed for Members age zero (0) and up.~~
 - ~~k.ii. Pediatricians: Auto-assignment allowed for Members preference, provider and service utilization, diagnosis, severity of condition, Health Needs Assessment, geography, and language up to age twenty-one (21).~~
- ~~1.a. Effective July 1, 2019, if a new Member who is known to be CCS-eligible or an existing Member who becomes CCS-eligible (while enrolled in a Health network that does not participate in the WCM program) CalOptima Health's Auto Assignment process will only allow a new CalOptima Health Member who is known to be CCS-eligible, to be assigned to~~

~~a participating Health Network. All other existing Auto-Assignment rules will apply, including accounting for allotted percentages for the Health Networks.~~

iii. Internal Medicine Providers: Auto-assignment allowed for Members eighteen (18) years of age and older.

f. Members may call in to request assignment to an OB/GYN if the provider has elected to serve as a PCP.

m.g. The number of Auto-Assigned Members a Health Networks that do not meet the WCM network certification requirements can become Network and PCPs receive may vary monthly, depending upon the number of Members eligible for the affected category of Auto-Assignment if they meet such requirements at a later date and are added to and the WCM network with Zip Code Match between a Member and a Health Network coverage area or the approval of DHCS PCP's coverage area.

n.c. Quality metrics and a minimum performance level on the established quality metrics shall be utilized to qualify a Health Network for Auto Assignment. CalOptima Health may suspend Auto-Assignment against a Health Network or CHCN if a Health Network or CHCN fails they fail to score at, or above, a specified performance level based on overall performance on established HEDIS indicators.

i.1. CalOptima Health Achievement of minimum performance levels on quality metrics is assessed annually. A Health Network that has been suspended from Auto-Assignment due to failure to meet minimum performance levels will be reassessed annually. Auto-Assignment will be reinstated when a Health Network has demonstrated that they meet the minimum performance levels established by CalOptima Health.

ii.2. CalOptima Health shall report to the Delegation Oversight Committee (DOC)- any Health Network that fails to meet established minimum performance levels. CalOptima Health shall provide written notice to any Health Network that fails to meet this threshold.

iii.3. Pursuant to CalOptima Health Policy HH.2002: Sanctions, CalOptima Health's Compliance Committee may impose penalties against a Health Network that fails to meet the minimum performance requirements.

iv.4. Minimum Health Network performance levels may be modified for future measurement years, pursuant to this policy. Any change in performance level expectations shall be approved by the Quality Assurance Committee (QAC) of the Board of Directors prior to implementation. CalOptima Health shall notify Health Networks of the change prior to the Implementation of changes to metrics or scoring of quality metrics. Notifications to the networks include discussion at Health Network Forum, Quality Forum, or other stakeholder forums that permit the Health Networks to be informed of planned changes to the quality metrics or scoring and also permit them to provide feedback on the proposed changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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

- B. CalOptima Health Policy AA.1207b: Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology
- C. CalOptima Health Policy AA.1207c: Performance-based Community Health Center Auto Assignment Allocation Methodology
- D. CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct
- E. CalOptima Health Policy DD.2006b: Member Primary Care Provider Selection/Assignment
- ~~F. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process~~
- ~~G.F.~~ CalOptima Health Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider
- ~~H.G.~~ CalOptima Health Policy HH.2002: Sanctions
- ~~I.H.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001: Network Certification Requirements (Supersedes APL 21-006)
- ~~J.I.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (Supersedes APL 22-032)
- ~~K.J.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/03/2006	Regular Meeting of the CalOptima Board of Directors
12/04/2007	Regular Meeting of the CalOptima Board of Directors
02/05/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
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03/06/2014	Regular Meeting of the CalOptima Board of Directors
10/06/2022	Regular Meeting of the CalOptima Health Board of Directors
05/07/2026	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	12/04/2007	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/05/2008	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	01/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	03/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2012	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	07/01/2013	AA.1207a	CalOptima Auto Assignment	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2016	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	10/06/2022	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	01/01/2024	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	06/01/2024	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	10/01/2025	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	07/01/2026	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
<u>Revised</u>		<u>AA.1207a</u>	<u>CalOptima Health Auto-Assignment</u>	<u>Medi-Cal</u> <u>Covered</u> <u>California</u>

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For 20261001 BOD Review

1 IX. GLOSSARY

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Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network or CalOptima Health Direct; and 3. Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan	<u>Covered California: A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), Covered California, Department of Managed Health Care (DMHC), 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 in accordance with HH.2005: Corrective Action Plan.</u> <u>Medi-Cal: A plan delineating specific and identifiable activities or undertaking 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 CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.</u>
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Healthcare Effectiveness Data and Information Set (HEDIS)	<u>Covered California: The data as reported and updated annually by the National Committee for Quality Assurance (NCQA). Individual Exchange: Covered California through which Qualified Individuals may purchase QHPs.</u> <u>Medi-Cal: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).</u>
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance

Term	Definition
	Organization (HMO), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Health Network Eligible Member	A member Member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CHCN).
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. An individual enrolled in a CalOptima Health program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.
Zip Code Match	The DHCS reported member's home address zip code must match to a zip code within the zip code range table in order for that clinic or health network to be eligible for the Member assignment.



Policy: AA.1207a
Title: **CalOptima Health Auto-Assignment**
Department: Provider Network Operations
Section: Provider Data Operations

CEO Approval: /s/

Effective Date: 01/01/2007

Revised Date:

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

I. PURPOSE

This policy establishes a process by which CalOptima Health assigns a Member to a Health Network or CalOptima Health Community Network (CHCN), and a Primary Care Provider (PCP).

II. POLICY

A. Upon eligibility with CalOptima Health, CalOptima Health shall assign Members to a Health Network and PCP in accordance with the terms and conditions of this policy to ensure the following:

1. Member access to health care services within required time and distance standards to their residence, as on file with CalOptima Health from eligibility files received from the Department of Health Care Services (DHCS) for the Medi-Cal Program and Covered California for the CalOptima Health Covered program.
2. Community Health Center safety net provider participation in the Medi-Cal program; and
3. Member enrollment in Health Networks or CHCN (for the Medi-Cal program) demonstrating quality performance.

B. CalOptima Health shall process eligibility and enrollment data received from the Department of Health Care Services (DHCS) and Covered California and assign a PCP and Health Network to each Member based on the following:

1. Previously assigned PCP and Health Network: If a Member is a returning Member to CalOptima Health and Member's previously assigned PCP and Health Network are active with CalOptima Health, Member shall be reassigned to the same PCP and Health Network to maintain continuity of care.
2. Family Links: For a Member where CalOptima Health system identifies a family member currently assigned to a PCP and Health Network, CalOptima Health will assign the Member to the same PCP and Health Network as the family member(s) provided the provider's specialty type is appropriate for the Member's age and gender.

- 1 3. Whole Child Model: Members who are eligible for the Whole Child Model program, where the
2 Member requires assignment to a PCP and/or Health Network with specific certifications,
3 specialties and coverage.
4
5 4. Auto Assignment: Members who have not been assigned a PCP and/or Health Network through
6 the above mechanism are assigned a PCP, Community Health Center, and/or Health Network
7 through the CalOptima Auto-Assignment processes. The Auto-Assignment process shall
8 identify the best match for a Member based on:
9
10 a. Geographic proximity to the Member's residence and within the maximum travel distance
11 standards specified by DHCS for Medi-Cal and DMHC for Covered California;
12
13 b. Age;
14
15 c. Gender;
16
17 d. Community Health Center Quality Rating (applicable to Medi-Cal Only);
18
19 e. Health Network Quality Rating; and
20
21 f. PCP and Health Network capacity.
22
23 C. Members may request to change their Health Network and/or PCP at any time, in accordance with
24 CalOptima Health Policy DD.2006b: Member Primary Care Provider and Health Network
25 Selection/Assignment.
26
27 D. For the Medi-Cal Program, CalOptima Health shall Auto-Assign no less than thirty-seven percent
28 (37%) of eligible Members to a Health Network or CHCN based on the Member's assignment to an
29 eligible community health center as a Primary Care Provider (PCP). CalOptima Health shall Auto-
30 Assign Members through the Health Network or CHCN level to the Community Health Center. If a
31 new Federally Qualified Health Center (FQHC), or FQHC-Look-Alike, enters the CalOptima
32 Health program, CalOptima Health shall increase the base Auto-Assignment allocation for
33 Community Health Centers by one percent (1%), not to exceed forty-five percent (45%). If a
34 FQHC, or FQHC-Look-Alike, terminates with the CalOptima Health program, CalOptima Health
35 shall decrease the total Auto-Assignment allocation by one percent (1%), not to fall below thirty-
36 seven percent (37%).
37

38 III. PROCEDURE 39

- 40 A. Medi-Cal: CalOptima Health shall Auto-Assign eligible Members to a Health Network or CHCN as
41 follows, and in the following order:
42
43 1. CalOptima Health shall Auto-Assign a Member to an existing contracted primary care physician
44 or a Community Health Center as the PCP.
45
46 a. A Member who loses and regains eligibility with CalOptima Health within a twelve (12)
47 month period shall be assigned to the most recent Health Network and PCP assigned to the
48 Member, willing to accept new and existing patients.
49
50 b. Should the Member's previous PCP no longer participate in the CalOptima program, a new
51 PCP shall be assigned, maintaining the member assignment to the previous Health Network.
52
53 c. Should the Member's previous health network not participate in the member's current
54 program at CalOptima Health and member's previous PCP is active with another

CalOptima Health Network for the same program, CalOptima Health shall maintain the member's assignment to the previous PCP and assign Member to the PCP's participating Health Network.

- d. Should a Member's previous PCP and Health Network not participate in the Member's respective CalOptima program, the Member will be auto-assigned to a participating Health Network and PCP.
2. In an effort to keep Members of the same family covered under one (1) Health Network or CHCN, and where possible, one PCP, CalOptima Health shall Auto-Assign Members by family unit in accordance with CalOptima Health Policy DD.2006b: CalOptima Health Community Network Member Primary Care Provider Selection/Assignment. If a Family Linked Member who is less than twenty-one (21) years of age has family members in more than one (1) Health Network or CHCN, CalOptima Health shall Auto-Assign such Family Linked Member to the same Health Network or CHCN as his or her sibling.
3. For the Whole-Child Model (WCM) Program/California Children Services Program (CCS), CalOptima shall assign Members in accordance with the following:
 - a. If the Family Linked Member is known to be eligible with the Whole-Child Model (WCM) program/California Children Services Program (CCS) and the Family Linked Member's sibling is assigned to a Health Network that does not participate in the WCM program whether excluded from doing so or otherwise, the Family Linked Member shall be assigned to a Health Network participating in the WCM program.
 - b. Notwithstanding any other provisions of this policy, CalOptima Health shall ensure, effective July 1, 2019, that CCS-eligible Members are not assigned, whether by Auto-Assignment or otherwise, to a Health Network that is excluded from participating in the WCM program.
 - c. An existing Member assigned to a Health Network who becomes CCS/WCM-eligible, or a new CCS/WCM Member, will be assigned to a participating Health Networks after consideration of factors, unique to each Member, such as current PCP and specialist relationships to the Member, Member's preference, provider and service utilization, diagnosis, severity of condition, Health Needs Assessment, geography, and language.
 - d. If a new Member who is known to be CCS-eligible or an existing Member who becomes CCS-eligible (while enrolled in a Health network that does not participate in the WCM program) CalOptima Health's Auto-Assignment process will only allow a new CalOptima Health Member who is known to be CCS-eligible, to be assigned to a participating Health Network. All other existing Auto-Assignment rules will apply, including accounting for allotted percentages for the Health Networks.
 - e. A Health Network that does not meet the WCM network certification requirements can become eligible for the WCM category of Auto-Assignment if the Health Network meets such requirements at a later date and is added to the WCM network with the approval of DHCS.
4. Notwithstanding any other provisions of this policy and if applicable, CalOptima Health shall assign a new Health Network-eligible Member to CHOC Health Alliance if:
 - a. The Member will be less than seven (7) months of age at the time of enrollment with CalOptima Health;

- 1 b. The Member does not have another Family Linked Member enrolled in a Health
2 Network/CHCN at the time of assignment; and
3
4 c. CHOC Health Alliance is not suspended from Auto-Assignment.
5
6 5. CalOptima Health shall allocate percentages of the remaining auto-assignment eligible Medi-
7 Cal Members to the Community Health Centers and Health Networks based on annual
8 qualifications and quality ratings outlined in Policies AA.1207b: Performance-based Health
9 Network and CalOptima Health Community Network Auto-Assignment Allocation
10 Methodology and Policy AA.1207c: Performance-based Community Health Center Auto-
11 Assignment Allocation Methodology.
12
13 6. CalOptima shall assign Members to individual Community Health Centers as the Member's
14 Primary Care Provider based on the Member's zip code match with a Community Health
15 Center's coverage. Members assigned to a Community Health Center shall be assigned to the
16 Health Network the Community Health Center has selected as the Health Network through
17 which they will receive their auto-assigned Members. CalOptima Health's auto-assignment to
18 the Community Health Centers shall maintain true for the following conditions and
19 requirements:
20
21 a. If CalOptima Health auto-assigns a Member to a Community Health Center as the
22 Member's PCP, the Member's Health Network or CHCN shall not reassign such Member to
23 a PCP that is not a Community Health Center unless the Member requests such
24 reassignment.
25
26 b. A Health Network or CHCN's receipt of Auto-Assigned Members from a Community
27 Health Center shall not affect the Health Network or CHCN's receipt of any other Auto-
28 Assigned Members.
29
30 c. Eligible Community Health Center shall annually submit an Auto-Assignment Participation
31 form, select CHCN or at least one (1) Health Network that shall receive its allocation of
32 Auto-Assigned Members. A Community Health Center may select CHCN or one (1) Health
33 Network that shall receive its allocation of pediatric Auto-Assigned Members, and CHCN
34 or one (1) Health Network that shall receive its allocation of adult Auto-Assigned Members.
35 If a Community Health Center intends to select or unselect CHCN or change the Health
36 Network which shall receive its allocation of Auto-Assigned Members, it shall notify
37 CalOptima Health's Provider Relations Department, in writing.
38
39 d. If a Community Health Center fails to select CHCN or at least one (1) Health Network that
40 shall receive its allocation of Auto-Assigned Members, CalOptima Health shall exclude that
41 Community Health Center from receiving any allocation of Auto-Assigned Members until a
42 Health Network, or CHCN, has been selected.
43
44 e. If the Community Health Center previously selected CHCN or a Health Network that has
45 been suspended for Auto-Assignment, the Community Health Center shall select an
46 alternate Health Network or CHCN to receive its allocation of Auto-Assigned Members.
47
48 7. CalOptima Health shall Auto-Assign eligible Members to a Health Network or CHCN based on
49 the Health Network or CHCN's score on the indicators listed in the Health Network or CHCN
50 Performance-based Auto Assignment Allocation Table, which shall be calculated pursuant to
51 CalOptima Health Policy AA.1207b: Performance-based Health Network and CalOptima
52 Health Community Network Auto-Assignment Allocation Methodology.
53

- 1 8. CalOptima Health shall assign any remaining Members to a Health Network with a Zip Code
2 Match, regardless of whether that Health Network's Auto-Assignment allocation has been
3 satisfied.
4
- 5 9. Effective July 1, 2026, CalOptima Health shall auto-assign Members to PCPs within each
6 Health Network in accordance with the criteria set forth below:
7
- 8 a. Family Linked Members in the same household will be assigned to the same PCP or
9 medical group where possible;
10
- 11 b. The PCP is within ten (10) miles of the Member's residence;
12
- 13 c. The PCP does not have an age range or gender restriction that applies to the Member;
14
- 15 d. The PCP is accepting new Members at the time of assignment;
16
- 17 e. Member age falls within the practice age range of PCP types as follows:
18
- 19 i. Family Medicine Providers and General Practice Providers: Auto-assignment allowed
20 for Members age zero (0) and up.
21
- 22 ii. Pediatricians: Auto-assignment allowed for Members up to age twenty-one (21).
23
- 24 iii. Internal Medicine Providers: Auto-assignment allowed for Members eighteen (18)
25 years of age and older.
26
- 27 10. CalOptima Health will not auto-assign Members to Obstetricians/Gynecologists (OB/GYN).
28 Members may call in to request assignment to an OB/GYN if the provider has elected to serve
29 as a PCP.
30
- 31 11. The number of Auto-Assigned Members a Health Network or CHCN and PCPs receive may
32 vary monthly, depending upon the number of Members eligible for Auto-Assignment and the
33 Zip Code Match between a Member and a Health Network or CHCN's coverage area or the
34 PCP's coverage area.
35
- 36 B. Covered California: CalOptima Health shall Auto-Assign CalOptima Health Covered Members to a
37 Health Network and PCP according to the following provisions:
38
- 39 1. CalOptima Health shall Auto-Assign a Member to an existing contracted provider or clinic
40 when provided with the data establishing the relationship by CalOptima Health or a network
41 provider or clinic as outlined in the Medi-Cal Procedure Section III.A.1.
42
- 43 2. A Member who is new to CalOptima Health Covered and has a family member with a
44 CalOptima Health program shall be assigned to the same provider, to ensure unity of family
45 within one Health Network and where possible, one PCP in accordance with Medi-Cal
46 Procedure Section III.A.2
47
- 48 3. A Members who is new to CalOptima Health Covered and has no family linkages within a
49 CalOptima Health Program shall be assigned to a Health Network and PCP.
50
- 51 4. CalOptima Health shall allocate auto-assignment to a Health Network based on annual
52 qualifications and quality ratings according to policy AA.1207b - Performance-based Health
53 Network and CalOptima Health Community Network Auto-Assignment Allocation
54 Methodology.

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5. Each Member assigned to a Health Network shall be assigned a PCP in accordance with the criteria set forth below:
- a. Family members in the same household will be assigned to the same PCP or Community Health Center where possible;
 - b. The PCP is within fifteen (15) miles of the Member's residence;
 - c. The PCP does not have an age range or gender restriction that applies to the Member;
 - d. The PCP is accepting new Members at the time of assignment;
 - e. Member age falls within the practice age range of PCP types as follows:
 - i. Family Medicine Providers and General Practice Providers: Auto-assignment allowed for Members age zero (0) and up.
 - ii. Pediatricians: Auto-assignment allowed for Members up to age twenty-one (21).
 - iii. Internal Medicine Providers: Auto-assignment allowed for Members eighteen (18) years of age and older.
 - f. Members may call in to request assignment to an OB/GYN if the provider has elected to serve as a PCP.
 - g. The number of Auto-Assigned Members a Health Network and PCPs receive may vary monthly, depending upon the number of Members eligible for Auto-Assignment and the Zip Code Match between a Member and a Health Network coverage area or the PCP's coverage area.
- C. Quality metrics and a minimum performance level on the established quality metrics shall be utilized to qualify a Health Network for Auto Assignment. CalOptima Health may suspend Auto-Assignment against a Health Network or CHCN if they fail to score at, or above, a specified performance level based on overall performance on established HEDIS indicators.
- 1. CalOptima Health Achievement of minimum performance levels on quality metrics is assessed annually. A Health Network that has been suspended from Auto-Assignment due to failure to meet minimum performance levels will be reassessed annually. Auto-Assignment will be reinstated when a Health Network has demonstrated that they meet the minimum performance levels established by CalOptima Health.
 - 2. CalOptima Health shall report to the Delegation Oversight Committee (DOC) any Health Network that fails to meet established minimum performance levels. CalOptima Health shall provide written notice to any Health Network that fails to meet this threshold.
 - 3. Pursuant to CalOptima Health Policy HH.2002: Sanctions, CalOptima Health's Compliance Committee may impose penalties against a Health Network that fails to meet the minimum performance requirements.
 - 4. Minimum Health Network performance levels may be modified for future measurement years, pursuant to this policy. Any change in performance level expectations shall be approved by the Quality Assurance Committee (QAC) of the Board of Directors prior to implementation. CalOptima Health shall notify Health Networks of the change prior to the Implementation of

changes to metrics or scoring of quality metrics. Notifications to the networks include discussion at Health Network Forum, Quality Forum, or other stakeholder forums that permit the Health Networks to be informed of planned changes to the quality metrics or scoring and also permit them to provide feedback on the proposed changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
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VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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Revised	02/05/2008	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	01/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	03/01/2011	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2012	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	07/01/2013	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2016	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	02/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	11/01/2017	AA.1207a	CalOptima Auto Assignment	Medi-Cal
Revised	10/06/2022	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	01/01/2024	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	06/01/2024	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	10/01/2025	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised	07/01/2026	AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal
Revised		AA.1207a	CalOptima Health Auto-Assignment	Medi-Cal Covered California

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1 IX. GLOSSARY

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Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network or CalOptima Health Direct; and 3. Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan	<u>Covered California</u>: 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), Covered California, Department of Managed Health Care (DMHC), 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 in accordance with HH.2005: Corrective Action Plan. <u>Medi-Cal</u>: A plan delineating specific and identifiable activities or undertaking 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 CAPs to ensure that they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Healthcare Effectiveness Data and Information Set (HEDIS)	<u>Covered California</u>: The data as reported and updated annually by the National Committee for Quality Assurance (NCQA). Individual Exchange: Covered California through which Qualified Individuals may purchase QHPs. <u>Medi-Cal</u>: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance

Term	Definition
	Organization (HMO), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Health Network Eligible Member	A Member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CHCN).
Member	An individual enrolled in a CalOptima Health program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.
Zip Code Match	The DHCS reported member's home address zip code must match to a zip code within the zip code range table in order for that clinic or health network to be eligible for the Member assignment.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Approve Revisions to CalOptima Health’s Community Relations Policies

Contacts

Veronica Carpenter, Chief Administrative Officer, (657) 900-1161

Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Action

Approve revisions to the following CalOptima Health community relations policies and related attachments, effective October 1, 2026:

1. CalOptima Health Policy AA.1214: Guidelines for Letters of Support and Use of CalOptima Health Name or Logo; and
2. CalOptima Health Policy AA.1223: Participation in and Sponsorship of Community Events by External Entities.

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. CalOptima Health’s two community relations policies were last revised on December 1, 2024.

Discussion

CalOptima Health Policy AA.1214: Guidelines for Endorsement by CalOptima Health, for Letters of Support and Use of CalOptima Health Name or Logo (Policy)

This policy establishes guidelines for providing Letters of Support (LOS) to external entities and for approving the use of the CalOptima Health name or logo by external entities.

Notably, the proposed revisions to Policy AA.1214 update terminology to better clarify current processes and incorporate additional LOS use cases affecting the Government Affairs department. This includes updating the title of the policy to *Policy AA.1214: Guidelines for Letters of Support and Use of CalOptima Health Name or Logo*.

The table below outlines the substantive changes to Policy AA.1214 that are reflected in the attached redline policy. The list does not include non-substantive changes that may also be reflected in the redline (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, or grammatical changes).

Section	Proposed Change
Title/ Throughout	Deletes and retires the use of the term Endorsement to avoid confusion with the plain language use of the word as it relates to political endorsements.
Throughout	Expands the provision of LOS for not only a “program” or “project” but also for an “effort” to align with current, broader uses.
Throughout	Changes use of the word “organization” to “entity” to broaden the application of requestors.
Throughout	Clarifies that CalOptima Health may use designees for approvals of an LOS or the use of CalOptima Health’s name or logo.
II.B	Clarifies that a public agency or official can request an LOS.
II.C	Clarifies that CalOptima Health’s name or logo cannot be used to imply support of a political campaign or candidate.
II.D	Added that a signature on an LOS constitutes approval of the LOS.
II.E	Clarifies that letters of validation or reference are not governed by this policy.
II.G	Clarifies the following: 1. Procedures for the use of CalOptima Health’s name or logo that are associated with an LOS or an event participation or sponsorship are governed by a separate section in the policy and a separate policy, CalOptima Health Policy AA.1223: Participation in and Sponsorship of Community Events by External Entities; and 2. This section only governs uses of CalOptima Health’s name or logo that are not associated with an LOS or an event participation or sponsorship.
II.G	Modifies the approval requirement for the use of CalOptima Health’s name or logo from the Chief Executive Officer (CEO) to the Director or Senior Director of Communications.
II.H. (original)	Removes the requirement that approved LOS and uses of CalOptima Health’s name or logo are not required to be separately posted to the CalOptima Health website beyond their inclusion in publicly posted CalOptima Health Board of Directors (Board) materials, as indicated in other sections.
III.A.1.a/b	Bifurcates the procedures for processing Government Affairs-related LOS from all other types of LOS.
III.A.3.a	Adds a new step to verify the “good standing” of an entity requesting an LOS.
III.B.3.a	Added a new step to verify the “good standing” of an entity requesting use of CalOptima Health’s name or logo.
Attachment A	Aligns the attachment with changes made in the policy itself.
Attachment B	Aligns the attachment with changes made in the policy itself.

Policy AA.1223: Participation in Community Events by External Entities

This policy establishes guidelines for CalOptima Health’s non-financial participation in and financial sponsorship of community events, programs, projects, and activities involving external entities.

Notably, the proposed revisions to Policy AA.1223 update terminology to better clarify current processes and incorporate additional use cases for events involving the Government Affairs department.

This includes updating the title of the policy to *AA.1223: Participation in and Sponsorship of Community Events by External Entities*.

The table below outlines the substantive changes to Policy AA.1223 that are reflected in the attached redline policy. The list does not include non-substantive changes that may also be reflected in the redline (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language, or grammatical changes).

Section	Proposed Change
Title	Adds Sponsorship to the title to align with updated definitions, as indicated in the following row.
Throughout	Bifurcates the definitions of Participation versus Sponsorship to clarify that Participation is non-financial support and Sponsorship is financial support.
Throughout	Clarifies the approval process and the use of designees related to CalOptima Health's Participation in or Sponsorship of an event.
Throughout	Adds a maximum advance submission time of no more than four (4) months for all types of requests to allow staff to better assess use of staff time and resources.
II.B	Adds "associations" to the list of entities eligible to apply for CalOptima Health's Participation in or Sponsorship of an event.
II.B	Adds a requirement that CalOptima Health events must be hosted in Orange County for members who reside in Orange County.
II.C	Clarifies that Sponsorships cannot be provided for events that are primarily used to raise funds for charitable purposes.
II.D	Clarifies that CalOptima Health cannot participate in political events.
II.E.4	Adds a new option for Participation in or Sponsorship of events related to Government Affairs activities.
II.G.2	Lowest the maximum threshold for CEO approval of an event Sponsorship from \$25,000 to \$10,000.
II.G.2.b	Clarifies that CalOptima Health has discretion to approve Sponsorships.
II.G.2.b	Clarifies that approval of an event Sponsorship also includes approval of Participation in that event.
II.G.3	Lowest the minimum threshold for Board approval from amounts greater than \$25,000 to amounts greater than \$10,000.
II.G.5 (original)	Removes the assessment of the use of CalOptima Health's non-monetary resources when determining the approval of CalOptima Health's Participation in or Sponsorship of an event to better align with current processes.
III.B	Adds a new step to verify the "good standing" of the entity requesting CalOptima Health's Participation in or Sponsorship of an event.
III.C.3	Clarifies that CalOptima Health may pay third-party vendors directly as part of an approved Sponsorship.
III.D.3	Modified thresholds for approving in-kind contributions of branded items.
Attachment A	Aligns the attachment with changes made in the policy itself.
Attachment B	Aligns the attachment with changes made in the policy itself.

Fiscal Impact

The recommended action is operational in nature and has no additional fiscal impact beyond what is included in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

The proposed revisions to Policies AA.1214 and AA.1223 address pertinent changes to align policy guidance with current operations and provide greater clarity on community relations and government affairs activities with external entities, in order to preserve and protect the name and reputation of CalOptima Health as a public agency.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy AA.1214: Guidelines for Letters of Support and Use of CalOptima Health Name or Logo (Redline & Clean Versions)
2. CalOptima Health Policy AA.1223: Participation in and Sponsorship of Community Events by External Entities (Redline & Clean Versions)

Policy: AA.1214
Title: **Guidelines for ~~Endorsements by CalOptima Health, for~~ Letters of Support and Use of CalOptima Health Name or Logo**

Department: Communications
Section: Community Relations

CEO Approval: /s/

Effective Date: 02/04/1997

Revised Date:

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

I. PURPOSE

This policy establishes guidelines for providing ~~an Endorsement to external entities by CalOptima Health, for~~ Letters of Support (LOS), ~~to external entities,~~ and for approving the use of the CalOptima Health name, or logo, by external entities.

II. POLICY

- A. CalOptima Health's name carries considerable value, particularly for external entities seeking to associate themselves with the organization. Moreover, CalOptima Health's role as a public agency requires that its name and reputation be preserved and protected, and that activities and ~~organizations/entities~~ associated with CalOptima Health's name must be consistent with CalOptima Health's mission and purpose. Requests for an ~~Endorsement, including~~ LOS and use of CalOptima Health name, or logo, shall be approved only if compatible with CalOptima Health's mission and in accordance with this policy.
- B. An external entity may be eligible to submit a request for an ~~Endorsement including requests for a~~ LOS, or Use of CalOptima Health name, or logo, if the entity is a community-based, non-profit organization, public agency or official, or health care partner, that serves CalOptima Health Members or supports CalOptima Health's mission.
- C. Except as provided in this ~~Policy~~ policy, CalOptima Health prohibits direct and implied ~~Endorsements~~ endorsements. The name, logo, or images of CalOptima Health may not be used in any statement, website, print, or electronic communication, or activity to explicitly, or implicitly, endorse any specific commercial product, or service, any religion, any ballot measure/initiative, or any candidate for public office. As such, CalOptima Health's name, logo, or images may not appear alongside those affiliated with a political campaign, including for a ballot measure/initiative or an incumbent or non-incumbent candidate for public office. CalOptima Health's name, logo, or images may only appear alongside those of an incumbent public official in his/her formal capacity

1 representing a government office. In addition, the name, logo, or images of CalOptima Health may
2 not be used explicitly, or implicitly, to endorse, or create, the appearance of partiality towards any
3 vendor, or particular health care provider.
4

- 5 D. Requests for an ~~Endorsement or~~ LOS, shall require the written approval of the Chief Executive
6 Officer (CEO), or his/her designee, whose signature on the LOS may constitute such approval.
7 The CEO, or his/her designee, shall consider such requests based on:

- 8
9 1. The potential for the ~~Endorsement or~~ LOS to create a positive visibility for CalOptima Health;
10
11 2. Whether the ~~Endorsement or~~ LOS would promote, or advocate, positions that are consistent
12 with CalOptima Health's mission, programs, standards, and purposes; and
13
14 3. Whether the ~~Endorsement or~~ LOS may conflict with CalOptima Health policies and/or
15 applicable local, state, and federal laws and regulations, and/or whether the ~~Endorsement, or~~
16 LOS, could constitute any real, or perceived, conflict of interest.
17

- 18 E. Requests for a letter validating matters of fact regarding the relationship between an external entity
19 and CalOptima Health, which may be referred to as a letter of reference, shall not be processed in
20 accordance with this policy. Such requests shall be considered by the appropriate internal
21 department(s) that can attest to the facts of the relationship between the external entity and
22 CalOptima Health, in accordance with any prescribed policies or procedures of such department(s).
23

- 24 E.F. Use or reproduction of the CalOptima Health name or logo by external entities shall be
25 restricted by CalOptima Health, in accordance with federal and state trademark rules and
26 regulations.
27

- 28 F.G. Requests to utilize the CalOptima Health name or logo for any ~~project, document, event, or~~
29 ~~other~~ purpose that is not separately prescribed by the LOS approval process, pursuant to Section
30 III.A. of this policy, and/or processes related to Participation in and/or Sponsorship of community
31 events, pursuant to CalOptima Health Policy AA.1223: Participation in and Sponsorship of
32 Community Events by External Entities, shall require the advance written approval of CalOptima
33 Health's CEO/Director or Senior Director of the Communications Department, or his/her designee,
34 pursuant to Section III.B.1. of this policy.
35

- 36 G.H. CalOptima Health shall report any ~~Endorsement or~~ LOS approved by the CEO, or his/her
37 designee, including the use of CalOptima Health's name or logo for any project, document, event, or
38 other purpose, to the CalOptima Health Board of Directors, in writing, at the next available regularly
39 scheduled Board of Directors meeting after such approval.
40

- 41 A. ~~An Endorsement, LOS, and use of CalOptima Health's name or logo as approved in accordance with~~
42 ~~this policy, shall be posted on CalOptima Health's website (www.CalOptimaHealth.org) and~~
43 ~~updated on a monthly basis.~~
44

- 45 H.I. CalOptima Health employees should refrain from wearing attire containing CalOptima Health's logo
46 while participating in non-CalOptima Health related activities, such as political fundraisers, in order
47 to avoid the appearance of CalOptima Health's ~~Endorsement~~ endorsement.
48

49 III. PROCEDURE

- 50
51 B. Requests for ~~Endorsements or an~~ LOS:
52 , including

1 A. ~~All~~ requests for CalOptima Health's name, or logo, to be added to an LOS drafted by an external
2 entity:

3
4 1. Requests shall be submitted to CalOptima Health's Community Relations Department, in
5 writing, at least twenty-one (21) calendar days in advance of the date for which the LOS is
6 requested, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so
7 long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient
8 amount of time so that CalOptima Health can complete a meaningful review and evaluation of
9 the request.

10
11 a. Requests from government entities or officials, requests related to government or public
12 grants, and/or requests related to public policy matters, including but not limited to
13 legislative and regulatory advocacy, shall be forwarded by the Community Relations
14 Department upon receipt to CalOptima Health's Government Affairs Department for
15 further processing in accordance with this policy.

16
17 a.b. All other requests shall be processed in accordance with this policy by the Community
18 Relations Department, which may, at its discretion, consult with the Government Affairs
19 Department.

20
21 2. A written request shall include the following information, as appropriate:

- 22
23 a. The name and description of the ~~organization~~entity seeking an ~~Endorsement or~~ LOS and the
24 ~~organization's~~entity's contact information;
- 25
26 b. Name of the program-~~or~~2 project, or effort, and name of the ~~program or project director, or~~
27 primary contact;
- 28
29 c. The reason for the request, including, but not limited to, a copy of the program-~~or~~2 project,
30 or effort description for which the ~~Endorsement, or~~ LOS~~;~~ is sought;
- 31
32 d. Scope and purpose of the program-~~or~~2 project, or effort, including the goal and the projected
33 outcome;
- 34
35 e. Description, background, and pertinent information (e.g., names of members of the Board of
36 Directors) regarding the requesting ~~organization~~entity and any other ~~organization~~entity
37 having a substantial role in the program, project, or effort;
- 38
39 f. Information regarding the ~~organization's~~entity's ability to successfully carry out the
40 program-~~or~~2 project, or effort;
- 41
42 g. A list of other individuals, or entities, supporting the program-~~or~~2 project, or effort;
- 43
44 h. Date ~~Endorsement or the~~ LOS is due to the ~~organization~~requesting entity;
- 45
46 i. Conditions under which the name of CalOptima Health and/or its logo will be used;
- 47
48 j. Draft template letter provided by the ~~organization~~entity, where applicable; and
- 49
50 k. Description of relationship between ~~organization's~~entity's work and CalOptima Health's
51 programs/lines of business, mission, values, and/or purpose.
52

1. ~~All requests shall be submitted at least twenty-one (21) calendar days in advance of the date for which the Endorsement or LOS is requested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima Health can complete a meaningful review and evaluation of the request.~~
3. Upon receipt of a complete request for an ~~Endorsement or~~ LOS, CalOptima Health's Community Relations Department, ~~or Government Affairs Department as applicable,~~ shall review and analyze the request with input from appropriate internal departments within five (5) business days of receipt of the complete request.
 - a. ~~The~~ As part of its review, the Community Relations Department, ~~or Government Affairs Department as applicable,~~ shall verify that the requesting entity is in good standing with the U.S. Department of Justice, the California Department of Justice, and the California Secretary of State.
4. The Community Relations Department, or Government Affairs Department as applicable, shall submit a request for ~~Endorsement or an~~ LOS to the CEO, or his/her designee, for review and ~~consideration~~ approval.
5. The Community Relations Department, ~~or Government Affairs Department as applicable,~~ shall notify the ~~organization~~ entity that requests an ~~Endorsement or~~ LOS in writing, after CalOptima Health's determination is made.
6. The Community Relations Department, ~~or Government Affairs Department as applicable,~~ shall process an approved ~~Endorsement or~~ LOS request within three (3) business days of approval.
7. The Community Relations Department, ~~or Government Affairs Department as applicable,~~ shall document and track all ~~Endorsements and~~ LOS and shall be responsible for fulfillment of any stated commitment(s).

C. ~~Use of the CalOptima Health name or logo:~~

8. The Community Relations Department shall consolidate and report all finalized LOS to the Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

B. Use of the CalOptima Health name or logo for a purpose that is not separately prescribed by the LOS approval process, pursuant to Section III.J. of this policy, and/or processes related to Participation in and/or Sponsorship of community events, pursuant to policy CalOptima Health Policy AA.1223: Participation in and Sponsorship of Community Events by External Entities:

1. Requests shall be submitted to CalOptima Health's Community Relations Department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name, or logo, is requested, or if in a shorter amount of time, at the discretion of the ~~CEO~~ Director or Senior Director of the Communications Department, or his/her designee, so long as such request is submitted to the ~~CEO~~ Director or Senior Director of the Communications Department, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima Health can complete a meaningful review and evaluation of the request.
2. Requests shall include the following:

- a. Description of the project, event, publication, or other purpose for which the CalOptima Health name, or logo will be used;
 - b. Intended audience for the project, event, or publication for which the name or logo will be used;
 - c. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting entity and any other entity whose name will appear on the document, project, or event;
 - d. Time frame during which the name or logo is requested to be used; and
 - e. Mock-up of how the name or logo will be used.
3. Upon receipt of a complete request for use of the CalOptima Health name or logo, CalOptima Health's ~~Community Relations~~ Communications Department shall review and analyze the request with input from appropriate internal departments within five (5) business days of receipt of the complete request.
 - a. As part of its review, the Communications Department shall verify that the requesting entity is in good standing with the U.S. Department of Justice, the California Department of Justice, and the California Secretary of State.
 4. The ~~Community Relations~~ Communications Department shall submit a request for use of the CalOptima Health name, or logo to the ~~CEO~~ Director or Senior Director of the Communications Department, or his/her designee, for review and ~~consideration~~ approval.
 5. The ~~Community Relations~~ Communications Department shall notify the requesting entity, in writing, after CalOptima Health's determination is made.
 6. The ~~Community Relations~~ Communications Department shall process an approved request within three (3) business days of approval.
 7. The ~~Community Relations~~ Communications Department shall document and track all ~~Endorsements and~~ use of the CalOptima Health name or logo and shall be responsible for fulfillment of any stated commitment(s).
 8. The Community Relations Department shall consolidate and report all use of the CalOptima Health name or logo to the Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

IV. ATTACHMENTS

- A. ~~Endorsement Request Form~~: Letter of Support & Use of Logo Request Form
- B. ~~Endorsement Transmittal Form~~: Letter of Support & Use of Logo Transmittal Form

V. REFERENCES

- A. California Constitution Article 16, Sec. 6
- B. California Government Code, §8314
- C. CalOptima Health Policy AA.1223: Participation in and Sponsorship of Community Events by

- 1 External Entities
2 D. CalOptima Health Policy GA.5002: Purchasing Policy
3 E. CalOptima Health Policy MA.2002: Marketing Activity Standards
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5 **VI. REGULATORY AGENCY APPROVAL**

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7 None to Date
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12 **VII. BOARD ACTIONS**
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Date	Meeting
10/02/2008	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors

14
15 **VIII. REVISION HISTORY**
16

Action	Date	Policy	Policy Title	Program
Effective	02/04/1997	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	07/01/2007	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	10/02/2008	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/02/2017	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	11/01/2018	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/01/2020	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	04/01/2021	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/01/2023	AA.1214	Guidelines for Endorsements by CalOptima Health and Use of CalOptima Health Name or Logo	Administrative
Revised	12/01/2024	AA.1214	Guidelines for Endorsements by CalOptima Health and Use of CalOptima Health Name or Logo	Administrative
Revised		<u>AA.1214</u>	<u>Guidelines for Letters of Support and Use of CalOptima Health Name or Logo</u>	<u>Administrative</u>

IX. GLOSSARY

Term	Definition
Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima Health does not receive a comparable benefit. Endorsement does not include any sponsorship, educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Letter of Support (LOS)	For purposes of this policy, a letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between CalOptima Health and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.
Marketing Activities Member	For purposes of this policy, 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 or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima Health. An individual enrolled in a CalOptima Health program.
Member	A beneficiary enrolled in a CalOptima Health program.

Policy: AA.1214
Title: **Guidelines for Letters of Support and Use of CalOptima Health Name or Logo**
Department: Communications
Section: Community Relations

CEO Approval: /s/

Effective Date: 02/04/1997

Revised Date:

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

I. PURPOSE

This policy establishes guidelines for providing Letters of Support (LOS) to external entities, and for approving the use of the CalOptima Health name, or logo, by external entities.

II. POLICY

- A. CalOptima Health's name carries considerable value, particularly for external entities seeking to associate themselves with the organization. Moreover, CalOptima Health's role as a public agency requires that its name and reputation be preserved and protected, and that activities and entities associated with CalOptima Health's name must be consistent with CalOptima Health's mission and purpose. Requests for an LOS and use of CalOptima Health name, or logo, shall be approved only if compatible with CalOptima Health's mission and in accordance with this policy.
- B. An external entity may be eligible to submit a request for an LOS, or Use of CalOptima Health name, or logo, if the entity is a community-based, non-profit organization, public agency or official, or health care partner that serves CalOptima Health Members or supports CalOptima Health's mission.
- C. Except as provided in this policy, CalOptima Health prohibits direct and implied endorsements. The name, logo, or images of CalOptima Health may not be used in any statement, website, print, or electronic communication, or activity to explicitly, or implicitly, endorse any specific commercial product, or service, any religion, any ballot measure/initiative, or any candidate for public office. As such, CalOptima Health's name, logo, or images may not appear alongside those affiliated with a political campaign, including for a ballot measure/initiative or an incumbent or non-incumbent candidate for public office. CalOptima Health's name, logo, or images may only appear alongside those of an incumbent public official in his/her formal capacity representing a government office. In addition, the name, logo, or images of CalOptima Health may not be used explicitly, or implicitly, to endorse, or create, the appearance of partiality towards any vendor, or particular health care provider.

- 1 D. Requests for an LOS shall require the written approval of the Chief Executive Officer (CEO), or
2 his/her designee, whose signature on the LOS may constitute such approval. The CEO, or his/her
3 designee, shall consider such requests based on:
4
5 1. The potential for the LOS to create a positive visibility for CalOptima Health;
6
7 2. Whether the LOS would promote, or advocate, positions that are consistent with CalOptima
8 Health's mission, programs, standards, and purposes; and
9
10 3. Whether the LOS may conflict with CalOptima Health policies and/or applicable local, state,
11 and federal laws and regulations, and/or whether the LOS could constitute any real, or
12 perceived, conflict of interest.
13
14 E. Requests for a letter validating matters of fact regarding the relationship between an external entity
15 and CalOptima Health, which may be referred to as a letter of reference, shall not be processed in
16 accordance with this policy. Such requests shall be considered by the appropriate internal
17 department(s) that can attest to the facts of the relationship between the external entity and
18 CalOptima Health, in accordance with any prescribed policies or procedures of such department(s).
19
20 F. Use or reproduction of the CalOptima Health name or logo by external entities shall be restricted by
21 CalOptima Health, in accordance with federal and state trademark rules and regulations.
22
23 G. Requests to utilize the CalOptima Health name or logo for any purpose that is not separately
24 prescribed by the LOS approval process, pursuant to Section III.A. of this policy, and/or processes
25 related to Participation in and/or Sponsorship of community events, pursuant to CalOptima Health
26 Policy AA.1223: Participation in and Sponsorship of Community Events by External Entities, shall
27 require the advance written approval of CalOptima Health's Director or Senior Director of the
28 Communications Department, or his/her designee, pursuant to Section III.B.1. of this policy.
29
30 H. CalOptima Health shall report any LOS approved by the CEO, or his/her designee, including the use
31 of CalOptima Health's name or logo for any project, document, event, or other purpose, to the
32 CalOptima Health Board of Directors, in writing, at the next available regularly scheduled Board of
33 Directors meeting after such approval.
34
35 I. CalOptima Health employees should refrain from wearing attire containing CalOptima Health's logo
36 while participating in non-CalOptima Health related activities, such as political fundraisers, in order
37 to avoid the appearance of CalOptima Health's endorsement.
38

39 III. PROCEDURE 40

- 41 A. Requests for an LOS, including requests for CalOptima Health's name, or logo, to be added to an
42 LOS drafted by an external entity:
43
44 1. Requests shall be submitted to CalOptima Health's Community Relations Department, in
45 writing, at least twenty-one (21) calendar days in advance of the date for which the LOS is
46 requested, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so
47 long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient
48 amount of time so that CalOptima Health can complete a meaningful review and evaluation of
49 the request.
50
51 a. Requests from government entities or officials, requests related to government or public
52 grants, and/or requests related to public policy matters, including but not limited to

1 legislative and regulatory advocacy, shall be forwarded by the Community Relations
2 Department upon receipt to CalOptima Health's Government Affairs Department for
3 further processing in accordance with this policy.
4

- 5 b. All other requests shall be processed in accordance with this policy by the Community
6 Relations Department, which may, at its discretion, consult with the Government Affairs
7 Department.
8

9 2. A written request shall include the following information, as appropriate:
10

- 11 a. The name and description of the entity seeking an LOS and the entity's contact
12 information;
13
14 b. Name of the program, project, or effort, and name of the primary contact;
15
16 c. The reason for the request, including, but not limited to, a copy of the program, project, or
17 effort description for which the LOS is sought;
18
19 d. Scope and purpose of the program, project, or effort, including the goal and the projected
20 outcome;
21
22 e. Description, background, and pertinent information (e.g., names of members of the Board of
23 Directors) regarding the requesting entity and any other entity having a substantial role in the
24 program, project, or effort;
25
26 f. Information regarding the entity's ability to successfully carry out the program, project, or
27 effort;
28
29 g. A list of other individuals, or entities, supporting the program, project, or effort;
30
31 h. Date the LOS is due to the requesting entity;
32
33 i. Conditions under which the name of CalOptima Health and/or its logo will be used;
34
35 j. Draft template letter provided by the entity, where applicable; and
36
37 k. Description of relationship between entity's work and CalOptima Health's programs/lines
38 of business, mission, values, and/or purpose.
39

40 3. Upon receipt of a complete request for an LOS, CalOptima Health's Community Relations
41 Department, or Government Affairs Department as applicable, shall review and analyze the
42 request with input from appropriate internal departments within five (5) business days of
43 receipt of the complete request.
44

- 45 a. As part of its review, the Community Relations Department, or Government Affairs
46 Department as applicable, shall verify that the requesting entity is in good standing with the
47 U.S. Department of Justice, the California Department of Justice, and the California
48 Secretary of State.
49

50 4. The Community Relations Department, or Government Affairs Department as applicable, shall
51 submit a request for an LOS to the CEO, or his/her designee, for review and approval.
52

- 1 5. The Community Relations Department, or Government Affairs Department as applicable, shall
2 notify the entity that requests an LOS in writing, after CalOptima Health's determination is
3 made.
- 4
- 5 6. The Community Relations Department, or Government Affairs Department as applicable, shall
6 process an approved LOS request within three (3) business days of approval.
- 7
- 8 7. The Community Relations Department, or Government Affairs Department as applicable, shall
9 document and track all LOS and shall be responsible for fulfillment of any stated
10 commitment(s).
- 11
- 12 8. The Community Relations Department shall consolidate and report all finalized LOS to the
13 Board of Directors, in writing, at the next available regularly scheduled Board of Directors
14 meeting after such approval.
- 15
- 16 B. Use of the CalOptima Health name or logo for a purpose that is not separately prescribed by the
17 LOS approval process, pursuant to Section III.J. of this policy, and/or processes related to
18 Participation in and/or Sponsorship of community events, pursuant to CalOptima Health Policy
19 AA.1223: Participation in and Sponsorship of Community Events by External Entities:
20
- 21 1. Requests shall be submitted to CalOptima Health's Community Relations Department, in
22 writing, at least twenty-one (21) calendar days in advance of the date for which use of the
23 name, or logo, is requested, or if in a shorter amount of time, at the discretion of the Director or
24 Senior Director of the Communications Department, or his/her designee, so long as such
25 request is submitted to the Director or Senior Director of the Communications Department, or
26 his/her designee, in a reasonable and sufficient amount of time so that CalOptima Health can
27 complete a meaningful review and evaluation of the request.
- 28
- 29 2. Requests shall include the following:
30
- 31 a. Description of the project, event, publication, or other purpose for which the CalOptima
32 Health name, or logo will be used;
- 33
- 34 b. Intended audience for the project, event, or publication for which the name or logo will be
35 used;
- 36
- 37 c. Description, background, and pertinent information (e.g., names of members of the Board of
38 Directors) regarding the requesting entity and any other entity whose name will appear on
39 the document, project, or event;
- 40
- 41 d. Time frame during which the name or logo is requested to be used; and
- 42
- 43 e. Mock-up of how the name or logo will be used.
- 44
- 45 3. Upon receipt of a complete request for use of the CalOptima Health name or logo, CalOptima
46 Health's Communications Department shall review and analyze the request with input from
47 appropriate internal departments within five (5) business days of receipt of the complete
48 request.
- 49
- 50 a. As part of its review, the Communications Department shall verify that the requesting
51 entity is in good standing with the U.S. Department of Justice, the California Department of
52 Justice, and the California Secretary of State.

4. The Communications Department shall submit a request for use of the CalOptima Health name or logo to the Director or Senior Director of the Communications Department, or his/her designee, for review and approval.
5. The Communications Department shall notify the requesting entity, in writing, after CalOptima Health's determination is made.
6. The Communications Department shall process an approved request within three (3) business days of approval.
7. The Communications Department shall document and track all use of the CalOptima Health name or logo and shall be responsible for fulfillment of any stated commitment(s).
8. The Community Relations Department shall consolidate and report all use of the CalOptima Health name or logo to the Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

IV. ATTACHMENTS

- A. Letter of Support & Use of Logo Request Form
- B. Letter of Support & Use of Logo Transmittal Form

V. REFERENCES

- A. California Constitution Article 16, Sec. 6
- B. California Government Code, §8314
- C. CalOptima Health Policy AA.1223: Participation in and Sponsorship of Community Events by External Entities
- D. CalOptima Health Policy GA.5002: Purchasing Policy
- E. CalOptima Health Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL

None to Date

VII. BOARD ACTIONS

Date	Meeting
10/02/2008	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	02/04/1997	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	07/01/2007	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	10/02/2008	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative

Action	Date	Policy	Policy Title	Program
Revised	02/02/2017	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	11/01/2018	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/01/2020	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	04/01/2021	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/01/2023	AA.1214	Guidelines for Endorsements by CalOptima Health and Use of CalOptima Health Name or Logo	Administrative
Revised	12/01/2024	AA.1214	Guidelines for Endorsements by CalOptima Health and Use of CalOptima Health Name or Logo	Administrative
Revised		AA.1214	Guidelines for Letters of Support and Use of CalOptima Health Name or Logo	Administrative

1

IX. GLOSSARY

Term	Definition
Letter of Support (LOS)	For purposes of this policy, a letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between CalOptima Health and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.
Member	An individual enrolled in a CalOptima Health program.

For 20261001 BOD Review Only



~~Endorsement Request Form~~ Letter of Support (LOS) & Use of Logo

Requests for Letter of Support (LOS) and/or Use of CalOptima Health's Logo must be submitted to the Community Relations Department no less than 21 calendar days in advance.

~~Endorsement Details~~

~~Organization:~~

~~Address:~~

~~City:~~

~~Zip
Code: *~~

~~POC Name & Title:~~

~~Phone Number:~~

~~Fax:~~

~~E-mail:~~

~~Type:~~

☐ Letter of Support

☐ Use of CalOptima Health's Name or Logo Only

☐ CalOptima Health's Master Logo

☐ OneCare Logo

☐ PACE Logo

~~Endorsement Needed By:~~

~~If more space is needed, you may attach additional pages.~~

~~1. Program or project description, including:~~

- ~~a. Name of the program or project;~~
- ~~b. Name of the program or project director or principle investigator, including his/her qualifications in regards to the program or project; and~~
- ~~c. Scope and purpose of the program or project~~



Endorsement Request Form – Letter of Support (LOS) & Use of Logo

2. Background information of requesting entity, including: a. Information regarding entity's ability to successfully carry out the program or project; and b. Names of members of the Board of Directors.	
3. Other individuals or entities supporting the program or project, including: a. A description of their role in the program or project.	
4. Detailed program or project timeline for planning, implementation, evaluation, and other phases of the program or project.	



Endorsement Request Form – Letter of Support (LOS) & Use of Logo

5. Projected outcome of the program or project.	
6. Purpose for CalOptima Health's involvement in the program or project, including: a. Detailed description of its proposed role; b. Anticipated time commitment required of CalOptima Health staff; and c. Specific data elements requested from CalOptima Health and a description of their specific use in the program or project.	
7. Conditions under which CalOptima Health's name and/or logo will be used.	



CalOptima Health

~~Endorsement Request Form – Letter of Support (LOS) & Use of Logo~~

8. Time frame during which CalOptima Health's name or logo will be used.	
9. Please provide a LOS template letter and/or mock-up of how CalOptima Health's name or logo will be used.	



~~Endorsement Transmittal Form:~~ Letter of Support (LOS) & Use of Logo

~~Guidelines for Endorsements by CalOptima Health~~

A CalOptima Health endorsement is given to projects and programs that are strongly aligned with our mission to provide members with access to quality health care services delivered in a cost- effective and compassionate manner. Endorsements are considered for programs and projects that:

1. Have the potential for the Endorsement or LOS to create positive visibility for CalOptima Health; and
2. Promote or advocate positions that are consistent with CalOptima Health's mission, programs, standards and purposes.

CalOptima Health will also consider whether the Endorsement or LOS may conflict with CalOptima Health policies and/or applicable local, state and federal laws and regulations, and/or whether the Endorsement or LOS could constitute any real or perceived conflict of interest.

Organization:	
Endorsement Needed By:	
Today's Date:	

~~Endorsement~~ Review

Required to go to the Board: No ☐ Yes ☐ (If approved by CEO)

Name	Signature	Date	Decision		Remarks
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	
			Yes ☐	No ☐	

CEO Approved:

Date:

~~For PA Department Use Only~~

Notification Sent:	
Reported for Board Update:	
Posted on CalOptima Health Website:	DELETE ROW
Notes:	

Policy: AA.1223
 Title: **Participation in and Sponsorship of Community Events by External Entities**
 Department: Communications
 Section: Community Relations

CEO Approval: /s/

Effective Date: 02/02/2017

Revised Date:

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

I. PURPOSE

This policy establishes guidelines for CalOptima Health's non-financial Participation in and financial Sponsorship of community events, programs, projects, and activities involving external entities.

II. POLICY

- A. CalOptima Health recognizes the value of partnering with external entities to provide additional health care related services to benefit the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima Health's Participation in or Sponsorship of community events involving external entities, ~~financially, or otherwise~~, shall be approved only if aligned with CalOptima Health's mission, vision and values.
- B. An external entity may be eligible for CalOptima Health's Participation in or Sponsorship of its event if the entity is a community-based, non-profit organization, health care partner, public or government entity, or association (collectively, "external entities") that serves CalOptima Health members who reside in Orange County or supports CalOptima Health's mission, vision and values. Religious organizations are not eligible for CalOptima Health's Participation or Sponsorship unless the event is open to the general public and is for a non-sectarian purpose. Events must be hosted in Orange County.
- ~~C.~~ The expenditure of CalOptima Health's funds shall only be made for a direct and primary public purpose within CalOptima Health's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima Health's authority and jurisdiction, CalOptima Health shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. CalOptima Health shall not provide Sponsorship of any event primarily used to raise funds for charitable purposes, including, but not limited to, galas, tournaments, fundraisers, dinners, ticketed dinner events, and walks.
- ~~C.D.~~ External entities may not use CalOptima Health's Participation or Sponsorship in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on

proposed legislation, ballot initiative, or proposition. As such, CalOptima Health's Participation in or Sponsorship of any event affiliated with a political campaign is strictly prohibited.

~~D.~~E. CalOptima Health's Participation or Sponsorship shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima Health representative;
2. A presentation, or panel presentation, by a CalOptima Health representative;
3. A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health information to members and/or potential members who could be enrolled in any of CalOptima Health's programs; ~~or~~
4. Opportunities to engage with government offices or officials, associations, or health care partners to advance strategic goals or public policy priorities for the benefit of CalOptima Health or its members, contracted providers, or other stakeholders; or
- 4.5. Other opportunity to meaningful opportunities to engage with Mmembers and/or potential Members to promote CalOptima Health's services and increase awareness about CalOptima Health.

~~E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (e.g., United Way), may be permitted based on a finding by the CalOptima Health Board of Directors that the request for financial Participation falls within CalOptima Health's authority and purpose, and meets one (1) of the following criteria:~~

- ~~1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima Health provides; or~~
- ~~2. There is an identifiable benefit to CalOptima Health and/or its members.~~

F. The expenditure of CalOptima Health funds and the use of resources, staff time, and CalOptima Health facilities shall not be inconsistent with, or in conflict with, CalOptima Health's obligations under applicable state and federal laws and contracts.

G. Requests for CalOptima Health's Participation ~~by CalOptima Health in~~ or Sponsorship of an event proposed by an external entity shall require approval as follows:

1. Requests for non-financial Participation, ~~other than financial contributions~~, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:
 - a. Requests ~~for non-financial Participation~~ from external entities shall be submitted no less than fourteen (14) calendar days, and no more than four (4) months, in advance of the date of the event.
 - b. The Chief Executive Officer (CEO), Director of the Community Relations Department, or his/her designee ~~is~~ their designees are authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

- 1 c. ~~Non financial Participation requests~~Requests from external entities for community/member-
- 2 oriented events such as health fairs, educational events, and/or community/town hall forums
- 3 shall meet the standards set forth above in Sections II.A. through II.F. ~~along with the~~
- 4 ~~following criteria:~~
- 5
- 6 i. ~~Member interaction/enrollment—The activity shall include Participation from~~
- 7 ~~CalOptima Health members and/or potential members that could be enrolled in any of~~
- 8 ~~CalOptima Health's programs, or be in furtherance of CalOptima Health's mission,~~
- 9 ~~vision & values, programs, and/or purpose; and~~
- 10
- 11 ii. ~~Inclusion of Details of the Event—Information about the organization and event,~~
- 12 ~~including name of the organization hosting the event, the name of the event itself,~~
- 13 ~~day/date, start and end time, location, event coordinator contact information, expected~~
- 14 ~~number of attendees, primary demographics of people served, purpose and outcome of~~
- 15 ~~the proposed event, and description of CalOptima Health's Participation in the event.~~
- 16
- 17
- 18 2. Requests for ~~financial Participation~~Sponsorship, up to and including, a cumulative value of
- 19 ~~twenty fiveten~~ thousand dollars (\$~~25~~10,000) per organization per fiscal year, which shall
- 20 include all materials and supplies:
- 21
- 22 a. Requests for ~~financial Participation~~Sponsorship in an amount up to and including ~~twenty-~~
- 23 ~~fiveten~~ thousand dollars (\$~~25~~10,000) per organization per fiscal year, inclusive of all
- 24 materials and supplies, shall be submitted no less than twenty-one (21) calendar days, and
- 25 no more than four (4) months, in advance of the date of the event, or if in a shorter amount
- 26 of time, at the discretion of the CEO, or his/her designee, so long as such request is
- 27 submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so
- 28 that CalOptima Health can complete a meaningful review and evaluation of the request.
- 29
- 30 b. The CEO, or his/her designee, is authorized to approve requests for ~~financial Participation~~
- 31 Sponsorship for qualifying external entities and events for a cumulative amount of up to and
- 32 including ~~twenty fiveten~~ thousand dollars (\$~~25~~10,000) per organization per fiscal year,
- 33 subject to availability of budgeted funds. Approval of Sponsorship shall be at the sole
- 34 discretion of CalOptima Health and subject to budget availability and alignment with
- 35 strategic priorities. Approval of Sponsorship shall also constitute approval of Participation in
- 36 the event.
- 37
- 38 c. All requests for ~~financial Participation~~Sponsorship to CalOptima Health from external
- 39 entities shall meet the standards set forth above in Sections II.A. through II.F. ~~along with the~~
- 40 ~~following criteria:~~
- 41
- 42 i. ~~Member interaction/enrollment—The activity shall include Participation from~~
- 43 ~~CalOptima Health members~~CEO, or his/her designee, is authorized to purchase and/or
- 44 ~~potential members that could be enrolled use in any-kind contributions of items branded~~
- 45 with CalOptima Health's programs or be in furtherance of logo for the purpose of
- 46 outreach and promoting CalOptima Health's mission, vision & values, programs, and/or
- 47 purpose;role and
- 48
- 49 d. ~~Inclusion of Details of the Event—Information about~~ services in the community.
- 50
- 51 3. Requests for Sponsorship in amounts of more than ten thousand dollars (\$10,000) per
- 52 organization and event, including the name of the per fiscal year:
- 53

1 a. Requests for Sponsorship in an amount of more than ten thousand dollars (\$10,000) per
2 organization hosting the event, the name per fiscal year shall be submitted no less than sixty
3 (60) calendar days, and no more than four (4) months, in advance of the date of the event
4 itself, day/date, start.

5
6 b. Requests from qualified external entities for Sponsorship which is valued at more than ten
7 thousand dollars (\$10,000) require approval from the CalOptima Health Board of Directors
8 and end time, location, event coordinator contact information, expected number of
9 attendees, primary demographics a finding that such Sponsorship is in the public good,
10 subject to availability of people served, purpose budgeted funds, and outcome of the
11 proposed event, description of within CalOptima Health's Participation in the
12 event, authority and statutory purpose. Approval of Sponsorship shall also constitute
13 approval of Participation in the event.

14
15 a-c. All requests for /or how Sponsorship to CalOptima Health's financial Participation will be
16 used, etc Health from external entities shall meet the standards set forth above in Sections
17 II.A. through II.F.

18
19 b.d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of
20 items branded with CalOptima Health's logo for the purpose of outreach and promoting
21 CalOptima Health's role and services in the community.

22
23 d. The CEO or his/her designee will report all approved Participation in events involving
24 financial Participation in an amount up to and including twenty five thousand dollars
25 (\$25,000) per organization per fiscal year to the CalOptima Health Board of Directors in the
26 CEO's regular Board communications, including, but not limited to, the CEO's weekly
27 updates and reports included in the next available regularly scheduled Board of Directors
28 meeting.

29
30 4. Requests for financial Participation in amounts of more than twenty five thousand dollars
31 (\$25,000) per organization per fiscal year:

32
33 a. Requests for financial Participation for the amount of more than twenty five thousand
34 dollars (\$25,000) per organization per fiscal year shall be submitted In no less than sixty
35 (60) calendar days in advance of the date of the event.

36
37 b.a. Financial requests from qualified external entities for eligible events valued at more than
38 twenty five thousand dollars (\$25,000) require shall approval from the CalOptima Health
39 Board of Directors and a finding that such financial Participation is in the public good,
40 subject to availability of budgeted funds, and within of CalOptima Health's authority and
41 statutory purpose. Participation in or Sponsorship of

42
43 c. All requests for financial Participation to CalOptima Health from external entities shall
44 meet the standards set forth above in Sections II.A. through II.F. along with the following
45 criteria:

46
47 i. Member interaction/enrollment—The activity shall include Participation from
48 CalOptima Health members and/or potential members that could be enrolled in any of
49 CalOptima Health's program, or be in furtherance of CalOptima Health's mission,
50 vision & values, programs, and/or purpose; and

51
52 ii. Inclusion of Details of the Event—Information about the organization and event,
53 including name of the organization hosting the event, the name of the event itself,

day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima Health's Participation in the event, and/or how CalOptima Health's financial Participation will be used, etc.

d. ~~The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima Health's logo for the purpose of outreach and promoting CalOptima Health's role and services in the community.~~

e. ~~The CEO or his/her designee will report all approved Participation in events involving financial Participation in amounts more than twenty five thousand dollars (\$25,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.~~

5. ~~In determining the value of CalOptima Health's Participation in events involving external entities, the following factors shall be considered:~~

a. ~~The use of CalOptima Health staff time (e.g., in their capacity as a CalOptima Health employee) to attend events such as health fairs, educational or community events;~~

b. ~~The use of CalOptima Health resources (e.g., CalOptima Health facilities);~~

c. ~~The use of current, or future, CalOptima Health eligible funds; and~~

d. ~~The value of items donated with the CalOptima Health master brand/logo.~~

H. ~~In no event shall approval of CalOptima Health's Participation in~~ an event, or with an external entity, constitute an ~~Endorsement~~endorsement of the external entity hosting the event, nor shall such Participation ~~or Sponsorship~~ constitute ~~Endorsement~~endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. ~~Endorsements and use~~Use of CalOptima Health's name, or logo, in any material by an external entity shall be governed by CalOptima Health Policy AA.1214: Guidelines for ~~Endorsements, for~~ Letters of Support, and Use of CalOptima Health's Name and Logo.

I. ~~The CEO, or his/her designee, shall report any all approved Participation approved by the CEO or Sponsorship to the CalOptima Health Board of -Directors, in writing, at the CEO's regular communications, including but not limited to the CEO's weekly email updates and the reports included in the meeting materials for the next available regularly scheduled Board of -Directors meeting after such approval.~~

J. ~~The CEO or his/her designee~~ Efforts shall be made to provide adequate advance notice of any events for which Participation or Sponsorship was approved to allow members of the CalOptima Health Board of Directors ~~with advanced notice, so they to~~ have the opportunity to attend such events ~~in which CalOptima Health participates.~~

K. ~~J.~~ Payment for actual and necessary expenses incurred in the course of performing services for CalOptima Health, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CalOptima Health Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima Health pay or reimburse a CalOptima Health employee for expenses arising from

personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

~~L.K.~~ In the event CalOptima Health's Participation in or Sponsorship of an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Health Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation or Sponsorship shall be submitted within the ~~timeframe~~timeframes specified above, and include the following information, as appropriate:

1. ~~Description~~Name and description of the external entity requesting Participation or Sponsorship, including, but not limited to: whether the external entity is a government entity, non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;
2. Description of the event, such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;
3. The purpose of the ~~event, event~~ including, but not limited to, a copy of any event materials, or description of the program or project;
4. Description of relationship between external entity's work, or event, and CalOptima Health's programs/lines of business, mission, vision & values, programs, and/or purpose;
5. Description, background, and pertinent information (e.g., names of members of the Board of Directors), including any potential conflicts of interest, interest regarding the requesting entity and any other entity having a substantial role in the event;
6. A list of other individuals, or entities, supporting the event;
- ~~7. Event budget information; and~~
- ~~7. Description of how the Sponsorship, if any, will be used.; and~~
8. Purpose, role, and anticipated time commitment for CalOptima Health's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation or Sponsorship, CalOptima Health's Community Relations Department shall:

1. Verify that the requesting entity is in good standing with the U.S. Department of Justice, the California Department of Justice, and the California Secretary of State;

1.2. Review and analyze the request to ensure eachall criteria is specified in Sections II are met and all information requested in Section III.A. is included;

2.3. Complete the Event Participation or Sponsorship Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3.4. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be notified.

C. Upon receipt of the approved request for Participation or Sponsorship from the CEO, his/her designee, or the Board of Directors, CalOptima Health's Community Relations Department shall:

1. Notify the requesting entity of CalOptima Health's determination; and
2. Process the ~~financial~~ Sponsorship request, if any, and any necessary documents within three (3) business days of the determination date.

3. CalOptima Health may issue direct payments to third-party vendors at the request of the external entity for which Sponsorship has been approved. The amount of any such payments shall be considered as part of the total amount of Sponsorship approved for the external entity.

3.4. Any payments for approved ~~financial requests~~ Sponsorship shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Health Logo:

1. Requests shall be submitted to CalOptima Health's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima Health master logo.
2. Upon receipt of a complete request to distribute items branded with the CalOptima Health master logo, CalOptima Health's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. Requests for a donation of items shall be considered for approval, as follows:

a. The Director of the Community Relations Department ~~shall submit a request to the Chief Executive Officer (CEO), or his/her designee for approval of,~~ is authorized to approve a donation of items valued at five dollars (\$5) or less, and up to and including a cumulative total of five hundred dollars (\$500) worth of goods.

b. Requests ~~to distribute~~ for a donation of items that exceed a cumulative total of five hundred dollars (\$500) up to and including a cumulative total of ten thousand dollars (\$10,000) shall be submitted to the CEO, or his/her designee, for approval.

a-c. Requests for donation of items that exceed a cumulative total of ten thousand dollars (\$10,000), shall require the prior approval of the CalOptima Health Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima Health's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima Health master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

- A. CalOptima Health ~~Public Activity~~ Event Participation or Sponsorship Request Form
B. CalOptima Health ~~Public Activity~~ Event Participation or Sponsorship Transmittal Form

V. REFERENCE(S)

- A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Health Policy AA.1214: Guidelines for ~~Endorsements by CalOptima Health, for~~ Letters of Support, and Use of CalOptima Health Name or Logo
D. CalOptima Health Policy GA.5004: Travel Policy
E. CalOptima Health Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	08/05/2021	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2022	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2023	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2024	AA.1223	Participation in Community Events by External Entities	Administrative
<u>Revised</u>		<u>AA.1223</u>	<u>Participation in Community Events by External Entities</u>	<u>Administrative</u>

1 IX. GLOSSARY

2

Term	Definition
<u>Marketing Activities</u> Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima Health does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of For purposes of this policy, 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 or to educate members and promote optimal program use and <u>Participation</u> . Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
<u>Participate/ Participation</u> Marketing Activities	For purposes of this policy, any activity conducted by or on behalf of this is the <u>in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade an external entity in support of one or influence eligible beneficiaries to enroll or to educate members and promote optimal program use</u> more events, programs, projects, and <u>Participation</u> . Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of or activities (collectively, “events”) in furtherance of CalOptima Health’s mission, vision & values, programs, and/or purpose.
<u>Sponsorship</u> Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima Health to an external entity in support of one or more events, programs, projects, and/or activities (collectively, “events”) in furtherance of CalOptima Health’s mission, vision & values, programs, and/or purpose.

3

Policy: AA.1223
Title: **Participation in and Sponsorship of Community Events by External Entities**
Department: Communications
Section: Community Relations

CEO Approval: /s/

Effective Date: 02/02/2017

Revised Date:

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

I. PURPOSE

This policy establishes guidelines for CalOptima Health's non-financial Participation in and financial Sponsorship of community events, programs, projects, and activities involving external entities.

II. POLICY

- A. CalOptima Health recognizes the value of partnering with external entities to provide additional health care related services to benefit the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima Health's Participation in or Sponsorship of community events involving external entities shall be approved only if aligned with CalOptima Health's mission, vision and values.
- B. An external entity may be eligible for CalOptima Health's Participation in or Sponsorship of its event if the entity is a community-based, non-profit organization, health care partner, public or government entity, or association (collectively, "external entities") that serves CalOptima Health members who reside in Orange County or supports CalOptima Health's mission, vision and values. Religious organizations are not eligible for CalOptima Health's Participation or Sponsorship unless the event is open to the general public and is for a non-sectarian purpose. Events must be hosted in Orange County.
- C. The expenditure of CalOptima Health's funds shall only be made for a direct and primary public purpose within CalOptima Health's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima Health's authority and jurisdiction, CalOptima Health shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. CalOptima Health shall not provide Sponsorship of any event primarily used to raise funds for charitable purposes, including, but not limited to, galas, tournaments, fundraisers, dinners, ticketed dinner events, and walks.
- D. External entities may not use CalOptima Health's Participation or Sponsorship in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on

proposed legislation, ballot initiative, or proposition. As such, CalOptima Health's Participation in or Sponsorship of any event affiliated with a political campaign is strictly prohibited.

E. CalOptima Health's Participation or Sponsorship shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima Health representative;
2. A presentation, or panel presentation, by a CalOptima Health representative;
3. A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health information to members and/or potential members who could be enrolled in any of CalOptima Health's programs;
4. Opportunities to engage with government offices or officials, associations, or health care partners to advance strategic goals or public policy priorities for the benefit of CalOptima Health or its members, contracted providers, or other stakeholders; or
5. Other meaningful opportunities to engage with Members and/or potential Members to promote CalOptima Health's services and increase awareness about CalOptima Health.

F. The expenditure of CalOptima Health funds and the use of resources, staff time, and CalOptima Health facilities shall not be inconsistent with, or in conflict with, CalOptima Health's obligations under applicable state and federal laws and contracts.

G. Requests for CalOptima Health's Participation in or Sponsorship of an event proposed by an external entity shall require approval as follows:

1. Requests for non-financial Participation, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:
 - a. Requests from external entities shall be submitted no less than fourteen (14) calendar days, and no more than four (4) months, in advance of the date of the event.
 - b. The Chief Executive Officer (CEO), Director of the Community Relations Department, or their designees are authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.
 - c. Requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F.
2. Requests for Sponsorship, up to and including, a cumulative value of ten thousand dollars (\$10,000) per organization per fiscal year, which shall include all materials and supplies:
 - a. Requests for Sponsorship in an amount up to and including ten thousand dollars (\$10,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days, and no more than four (4) months, in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima Health can complete a meaningful review and evaluation of the request.

- 1 b. The CEO, or his/her designee, is authorized to approve requests for Sponsorship for
2 qualifying external entities and events for a cumulative amount of up to and including ten
3 thousand dollars (\$10,000) per organization per fiscal year, subject to availability of
4 budgeted funds. Approval of Sponsorship shall be at the sole discretion of CalOptima Health
5 and subject to budget availability and alignment with strategic priorities. Approval of
6 Sponsorship shall also constitute approval of Participation in the event.
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8 c. All requests for Sponsorship to CalOptima Health from external entities shall meet the
9 standards set forth above in Sections II.A. through II.F.
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11 d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of
12 items branded with CalOptima Health's logo for the purpose of outreach and promoting
13 CalOptima Health's role and services in the community.
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15 3. Requests for Sponsorship in amounts of more than ten thousand dollars (\$10,000) per
16 organization per fiscal year:
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18 a. Requests for Sponsorship in an amount of more than ten thousand dollars (\$10,000) per
19 organization per fiscal year shall be submitted no less than sixty (60) calendar days, and no
20 more than four (4) months, in advance of the date of the event.
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22 b. Requests from qualified external entities for Sponsorship which is valued at more than ten
23 thousand dollars (\$10,000) require approval from the CalOptima Health Board of Directors
24 and a finding that such Sponsorship is in the public good, subject to availability of budgeted
25 funds, and within CalOptima Health's authority and statutory purpose. Approval of
26 Sponsorship shall also constitute approval of Participation in the event.
27
28 c. All requests for Sponsorship to CalOptima Health from external entities shall meet the
29 standards set forth above in Sections II.A. through II.F.
30
31 d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of
32 items branded with CalOptima Health's logo for the purpose of outreach and promoting
33 CalOptima Health's role and services in the community.
34
35 H. In no event shall approval of CalOptima Health's Participation in or Sponsorship of an event, or
36 with an external entity, constitute an endorsement of the external entity hosting the event, nor shall
37 such Participation or Sponsorship constitute endorsement of any particular message, or initiative,
38 commercial product or service, and/or any message advocated by the external entity. Use of
39 CalOptima Health's name, or logo, in any material by an external entity shall be governed by
40 CalOptima Health Policy AA.1214: Guidelines for Letters of Support, and Use of CalOptima
41 Health's Name and Logo.
42
43 I. The CEO, or his/her designee, shall report all approved Participation or Sponsorship to the
44 CalOptima Health Board of Directors in the CEO's regular communications, including but not
45 limited to the CEO's weekly email updates and the reports included in the meeting materials for the
46 next available regularly scheduled Board of Directors meeting after such approval. Efforts shall be
47 made to provide adequate advance notice of any events for which Participation or Sponsorship was
48 approved to allow members of the CalOptima Health Board of Directors to have the opportunity to
49 attend such events.
50
51 J. Payment for actual and necessary expenses incurred in the course of performing services for
52 CalOptima Health, including expenses incurred in the course of attending functions of external
53 entities, shall be reimbursed, or paid in accordance with CalOptima Health Policy GA.5004: Travel

Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima Health pay or reimburse a CalOptima Health employee for expenses arising from personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

- K. In the event CalOptima Health's Participation in or Sponsorship of an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Health Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

- A. All requests for Participation or Sponsorship shall be submitted within the timeframes specified above, and include the following information, as appropriate:

1. Name and description of the external entity requesting Participation or Sponsorship, including, but not limited to: whether the external entity is a government entity, non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;
2. Description of the event, such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;
3. The purpose of the event including, but not limited to, a copy of any event materials, or description of the program or project;
4. Description of relationship between external entity's work, or event, and CalOptima Health's programs/lines of business, mission, vision & values, programs, and/or purpose;
5. Description, background, and pertinent information (e.g., names of members of the Board of Directors), including any potential conflicts of interest regarding the requesting entity and any other entity having a substantial role in the event;
6. A list of other individuals, or entities, supporting the event;
7. Description of how the Sponsorship, if any, will be used.; and
8. Purpose, role, and anticipated time commitment for CalOptima Health's involvement in the event, if applicable.

- B. Upon receipt of a complete request for Participation or Sponsorship, CalOptima Health's Community Relations Department shall:

1. Verify that the requesting entity is in good standing with the U.S. Department of Justice, the California Department of Justice, and the California Secretary of State;
2. Review and analyze the request to ensure all criteria specified in Sections II are met and all information requested in Section III.A. is included;

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3. Complete the Event Participation or Sponsorship Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;
 4. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be notified.
- C. Upon receipt of the approved request for Participation or Sponsorship from the CEO, his/her designee, or the Board of Directors, CalOptima Health's Community Relations Department shall:
1. Notify the requesting entity of CalOptima Health's determination; and
 2. Process the Sponsorship request, if any, and any necessary documents within three (3) business days of the determination date.
 3. CalOptima Health may issue direct payments to third-party vendors at the request of the external entity for which Sponsorship has been approved. The amount of any such payments shall be considered as part of the total amount of Sponsorship approved for the external entity.
 4. Any payments for approved Sponsorship shall be issued only through checks, and no cash disbursements will be made for events covered by this Policy.
- D. Requests for In-Kind Contributions of Items Branded with the CalOptima Health Logo:
1. Requests shall be submitted to CalOptima Health's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima Health master logo.
 2. Upon receipt of a complete request to distribute items branded with the CalOptima Health master logo, CalOptima Health's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.
 3. Requests for a donation of items shall be considered for approval, as follows:
 - a. The Director of the Community Relations Department, or his/her designee, is authorized to approve a donation of items up to and including a cumulative total of five hundred dollars (\$500) worth of goods.
 - b. Requests for a donation of items that exceed a cumulative total of five hundred dollars (\$500) up to and including a cumulative total of ten thousand dollars (\$10,000) shall be submitted to the CEO, or his/her designee, for approval.
 - c. Requests for donation of items that exceed a cumulative total of ten thousand dollars (\$10,000), shall require the prior approval of the CalOptima Health Board of Directors.
 5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima Health's determination is made.
 6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima Health master logo within three (3) business days of approval.
 7. The requesting entity shall agree to return any items that it does not distribute at the conclusion

of the event for which the item was used.

IV. ATTACHMENT(S)

- A. CalOptima Health Event Participation or Sponsorship Request Form
- B. CalOptima Health Event Participation or Sponsorship Transmittal Form

V. REFERENCE(S)

- A. California Constitution Article 16, §6
- B. California Government Code, §8314
- C. CalOptima Health Policy AA.1214: Guidelines for Letters of Support, and Use of CalOptima Health Name or Logo
- D. CalOptima Health Policy GA.5004: Travel Policy
- E. CalOptima Health Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	08/05/2021	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2022	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2023	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	12/01/2024	AA.1223	Participation in Community Events by External Entities	Administrative
Revised		AA.1223	Participation in Community Events by External Entities	Administrative

1 IX. GLOSSARY

2

Term	Definition
Marketing Activities	For purposes of this policy, 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 or to educate members and promote optimal program use and Participation.
Participate/ Participation	For purposes of this policy, this is the in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima Health to an external entity in support of one or more events, programs, projects, and/or activities (collectively, “events”) in furtherance of CalOptima Health’s mission, vision & values, programs, and/or purpose.
Sponsorship	For purposes of this policy, this is the provision of financial assistance by CalOptima Health to an external entity in support of one or more events, programs, projects, and/or activities (collectively, “events”) in furtherance of CalOptima Health’s mission, vision & values, programs, and/or purpose.

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For 20261001 BOD Review ONLY

Public Activity Participation Request Form

Requesting Entity:	
Requesting Entity's principal office/base operations location:	
How long Requesting Entity has been operating:	
Requesting Entity's service areas:	
Description of relationship between Requesting Entity's work/event and CalOptima Health's programs, mission, vision, values and/or purpose:	Event provides CalOptima Health an opportunity to educate and outreach to current/potential members about programs and services available to eligible individuals.
Description, background and pertinent information (e.g., members of Board of Directors) and other entities with a substantial role in event:	Staff is not aware of CalOptima Health's Board members, advisory committee members, leaders or other departments' participation in this event.
List of individuals or entities supporting the event:	Staff is not aware of any individuals or entities supporting the event.
Entity type:	☐ Non-Profit Org ☐ For-Profit Org ☐ Religious Org ☐ Health Care Partner

Section I: Event Details			
Name:			
Day/Date:			
Start time:		End time:	
Location:			
City:		ZIP code:	
POC name:			
Phone #:		Fax #:	
Email:			
Type of event	☐ Opportunity to outreach to members or potential members ☐ Opportunity to outreach to health care professionals, non-profit orgs or policy makers ☐ Other:		
Expected # of Attendees:			

Section II: About the Attendees (check all that apply)	
Primary language spoken:	☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____
Event for:	☐ Children ☐ Persons with disabilities ☐ Low-income families ☐ General public ☐ Low-income older adult/seniors ☐ Other: _____
Event for CalOptima Health's Program:	☐ OneCare ☐ PACE ☐ Medi-Cal 

Section III: Cost to CalOptima Health to Participate	
Registration fee:	☐ No ☐ Yes, amount: _____
Sponsorship request:	☐ No ☐ Yes, amount: _____

Section IV: Notes/Comments

Section V: Disclosures
Requests must be submitted to the Community Relations department: Staff Participation (14) calendar days in advance; Financial Participation at or under \$25,000 (21) calendar days in advance; Financial Participation more than \$25,000 (60) calendar days in advance. [All event materials/information must be attached.]



Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Soledad Rivera at soledad.rivera@caloptima.org if you have any questions.

Today's Date: _____ Complete Routing By: _____

Routing Order			
1. Department POC:		Complete Review By:	
2. Department POC:		Complete Review By:	
3. Department POC:		Complete Review By:	

For CR Use Only: CR Initial Review

Requests for CalOptima Health 's Participation in community events involving external entities must be:			
Compatible with CalOptima Health 's mission to serve member health with excellence and dignity, respecting the value and needs of each person.	☐ Yes	☐ No	
Consistent with CalOptima Health 's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No	
In accordance with CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No	

CalOptima Health 's Participation shall include at least one (1) of the following:			
A speaking opportunity for a CalOptima Health representative	☐ Yes	☐ No	
A presentation, or panel presentation, by a CalOptima Health representative	☐ Yes	☐ No	
A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health information to members/potential members	☐ Yes	☐ No	
Other opportunity to promote CalOptima Health 's services and increase awareness about CalOptima Health	☐ Yes	☐ No	

Financial Participation must meet one (1) of the following criteria, if applicable:			
The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima Health provides	☐ Yes	☐ No	
There is an identifiable benefit to CalOptima Health and/or its members	☐ Yes	☐ No	

Board of Directors Approval Required if an Entity Exceeds the \$25,000 per Fiscal Year Limit:			
Is the requesting entity acting as the fiscal agent?	☐ Yes	☐ No	
Has CalOptima Health provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐ Yes	☐ No	
Does the cumulative total for this FY exceed the \$25,000 limit per entity, which requires Board approval?	☐ Yes	☐ No	
If yes, then date of Board of Directors approval:	☐ Yes	☐ No	

**Other considerations:**

Process as an Endorsement (i.e., CalOptima Health Policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, WCM FAC or Employee	☐ Yes	☐ No
Request Legal Review (i.e., conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes	☐ No
CalOptima Health participated in the past	☐ Yes	☐ No

Notes:**CR Participation Commitment:**

	YES	NO	NA
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e., registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐ TBD	☐	☐
Provide brochures/educational materials	☐ Program and Service fliers	☐	☐
Other:	☐ Specify	☐	☐

Notes:**Signature Required ~~Only for Sponsorships, Endorsements and Registration Fees.~~****Date:****Soledad Rivera, Manager of ~~Community Relations~~**

***CalOptima Health 's CEO has delegated authority to approve requests for financial participation in an amount up to and including \$25,000 if it is determined that CalOptima Health 's participation is of public purpose.**

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve Modifications to Utilization Management Policies GG.1500 and GG.1508

Contacts

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

Kelly Giardina, MSG, CCM, Executive Director Clinical Operations, (657) 900-1013

Recommended Action

Approve modifications to CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, and CalOptima Health Policy GG.1508: Authorization and Processing of Referrals, effective October 1, 2026.

Background

CalOptima Health regularly reviews its policies to ensure they are current and aligned with federal and state health care program requirements, regulatory and contractual obligations, and CalOptima Health's operations. The attached policies have been updated to align with industry best practices and to provide consistent retrospective criteria across all CalOptima Health product lines.

Discussion

Staff revised CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Health Providers and Policy GG.1508: Authorization and Processing of Referrals to clarify and strengthen the criteria for a retrospective authorization review. In addition, staff updated the policies to specify that a provider or practitioner must submit a retrospective review request for OneCare, Medi-Cal, and Covered California within thirty (30) calendar days of the initial date of service and only when extenuating circumstances prevented timely prior authorization.

The revised policies narrow acceptable retrospective review circumstances to one (1) of the following conditions:

1. Coordination of benefits when the member has other health coverage;
2. The member's medical condition is such that the provider or practitioner is unable to verify the member's eligibility for Medi-Cal, OneCare, or Covered California as applicable, and CalOptima Health eligibility at the time of service; or
3. The member's medical condition requires additional immediate medical need during a planned procedure.

These changes are intended to improve consistency in authorization review practices and reinforce safeguards against inappropriate retrospective review.

Fiscal Impact

The recommended action to approve modifications to these policies is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

CalOptima Health Board of Directors approval is recommended to adopt revisions to Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Health Providers and Policy GG.1508: Authorization and Processing of Referrals so that CalOptima Health's utilization management policies are aligned with applicable regulatory guidance. The updated policies clarify authorization procedures for providers, improve consistency in utilization management review requirements, and support compliance with state and federal program expectations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers](#)
2. [CalOptima Health Policy GG.1508: Authorization and Processing of Referrals](#)

Policy: GG.1500
 Title: **Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers**

Department: Utilization Management

Section: Not Applicable

CEO Approval: /s/

Effective Date: 07/01/1997

Revised Date:

Applicable to:

- ☐ Administrative
- ☒ Covered California
- ☒ Medi-Cal
- ☒ OneCare
- ☐ PACE

I. PURPOSE

To define the process by which a Provider or Practitioner shall obtain authorization for Covered Services for a CalOptima Health Direct (COHD) ~~or~~ CalOptima Health Community Network (CHCN) Member, or a Health Network Member including Prior Authorization, Concurrent Review, and Retrospective Review.

II. POLICY

A. A Provider or Practitioner shall request Prior Authorization, Concurrent Review and Retrospective Review for Covered Services listed on the CalOptima Health **Prior** Authorization Required List, available at www.caloptima.org, in accordance with this Policy, except as provided in CalOptima Health ~~Policy~~ Policies CC.1600: Authorization and Processing of Referrals and GG.1508: Authorization and Processing of Referrals.

1. A Provider or Practitioner requests authorization for elective inpatient services, elective outpatient services, elective ancillary services, and Post-Stabilization Care Services after an emergency admission, prior to rendering such Covered Services to a Member.
2. A Provider or Practitioner may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request. A Retrospective Review must meet criteria in Section II.A.2.a and one (1) of the following conditions apply criteria in Section II.A.2.b:

a. ~~The~~ When submitted within the appropriate Retrospective submission timeframe:

- i. For a OneCare Member a request must be made within thirty (30) calendar days after the initial date of service.
- ii. For a Medi-Cal Member a request must be made within thirty (30) calendar days after the initial date of service.

1
2 iii. For a Covered California Member, a request must be made within thirty (30) calendar
3 days after the initial date of service, and

4
5 b. One (1) of the following conditions must apply:

6
7 ii.i. Coordination of benefits (COB) when the Member has Other Health Coverage (OHC);

8
9 ii. The Member's medical condition is such that the Provider or Practitioner is unable to
10 verify the Member's eligibility for Medi-Cal ~~or~~, OneCare, or Covered California as
11 applicable, and CalOptima Health eligibility at the time of service; or

12
13 ii.iii. The Member's medical condition requires additional, immediate medical need during
14 a planned procedure.

15
16 ~~a. Retrospective submission timeframe:~~

17
18 ~~a. For a OneCare Member as long as such request is made within sixty (60) calendar days~~
19 ~~after the initial date of service.~~

20
21 ~~b. For a Medi-Cal Member as long as such request is made within a reasonable established~~
22 ~~time limit, not to exceed sixty (60) calendar days from the date of service.~~

23
24 3. A Provider or Practitioner requests authorization for Covered Services rendered to a Member
25 who is retroactively eligible for the CalOptima Health program within ~~one hundred twenty~~
26 ~~(120)~~ thirty (30) calendar days after the Member's retroactive eligibility determination is
27 available in the State of California Beneficiary Eligibility Verification System or California
28 Healthcare Eligibility, Enrollment and Retention System (CalHEERS) for Members enrolled in
29 Covered California.

30
31 4. Transplant Services: ~~If~~ For a Medi-Cal or OneCare if the Member is enrolled in a Health
32 Network, the Provider shall request authorization for Transplant evaluation services from
33 CalOptima Health.

34
35 B. CalOptima Health and its Health Networks shall ensure that clinical decisions made related to
36 coverage or denial of requested services due in whole or in part to Medical Necessity are consistent
37 and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1508:
38 Authorization and Processing of Referrals, ~~and~~ GG.1535: Utilization Review Criteria and
39 Guidelines and CC.1600 Authorization and Processing of Referrals.

40
41 C. Contracted and Non-Contracted Emergency Service Providers

42
43 1. The attending emergency physician, or the Provider treating the Member, is responsible for
44 determining when the Member is sufficiently stabilized for transfer or discharge, and that
45 determination is binding on CalOptima Health.

46
47 2. Emergency Services are not subject to Prior Authorization by CalOptima Health, and
48 CalOptima Health shall not limit what constitutes an Emergency Medical Condition on the basis
49 of lists of diagnoses or symptoms. CalOptima Health shall follow the standard definition of a
50 Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an
51 emergency.
52

1 a. The attending emergency physician, or the Provider treating the Member, is responsible for
2 determining when the Member is sufficiently stabilized for transfer or discharge, and that
3 determination is binding on such Member's assigned Health Network or on CalOptima
4 Health if such Member is a CalOptima Health Direct Member, whichever is applicable.

5
6 b. A plan health professional shall be available to the emergency room personnel treating the
7 Member, for consultation and for general communication, in accordance with CalOptima
8 Health ~~Policy GG.1508:~~Policies GG.1508: Authorization and Processing of Referrals and
9 CC.1600 Authorization and Processing of Referrals.

10
11 ~~C.D.~~ A hospital shall notify CalOptima Health within twenty-four (24) hours of a Member's Initial
12 Emergency Encounter in accordance with CalOptima Health ~~Policy~~Policies GG.1508:
13 Authorization and Processing of Referrals and CC.1600 Authorization and Processing of Referrals.
14 See Section III.D. of this policy for Prior Authorization Requests for Post-Stabilization Care
15 Services for Medically Necessary Post-Stabilization Care Services from Contracted Providers and
16 Non-Contracted Providers.

17
18 ~~D.E.~~ A Provider or Practitioner shall obtain authorization for the following services, in accordance
19 with specified CalOptima Health policies:

- 20
21 1. Services for a Member who meets California Children's Services (CCS) eligibility criteria, in
22 accordance with CalOptima Health Policy CalOptima Health ~~Policy~~Policies
23 GG.1508: Authorization and Processing of Referrals and CC.1600 Authorization and
24 Processing of Referrals;
- 25
26 2. Medical Supplies, in accordance with CalOptima Health Policies GG.1401: Physician
27 Administered Drug (PAD) Prior Authorization Process, GG.1508: Authorization and Processing
28 of Referrals, ~~and~~ MA.6101: Coverage Determination, and CC.1600 Authorization and
29 Processing of Referrals;
- 30
31 3. Disposable incontinence supplies, in accordance with CalOptima Health Policy GG.1114:
32 Authorization for Disposable Incontinence Supplies;
- 33
34 4. Durable Medical Equipment, in accordance with CalOptima Health Policy GG.1502: Criteria
35 and Authorization for Durable Medical Equipment (DME), Excluding Wheelchairs;
- 36
37 5. Wheelchair rental, purchase, or repair, in accordance with CalOptima Health Policy GG.1531:
38 Criteria and Authorization for Wheelchair ~~Rental, Purchase, and Repair~~Seating Equipment;
- 39
40 6. Non-emergency medical transportation and non-medical transportation, in accordance with
41 CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-
42 Medical;
- 43
44 7. Hospice services, in accordance with CalOptima Health Policy GG.1503: CalOptima Health
45 Hospice Coverage and Authorization Requirements;
- 46
47 8. Pharmacy services, in accordance with CalOptima Health Policies GG.1401: Physician
48 Administered Drug (PAD) Prior Authorization Process, and MA.6101: Medicare Part D
49 Coverage Determination; and
- 50
51 9. Applied Behavioral Analysis (ABA) services and Psychological Testing, in accordance with
52 CalOptima Health Policy GG.1548: Authorization and Monitoring of -Behavioral Health
53 Treatment (BHT) Services.

F.C. A Provider or Practitioner may appeal CalOptima Health’s utilization management (UM) decision, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process, MA.9003: Standard Pre-Service Appeal, and MA.9004: Expedited Pre-Service Integrated Appeal.

F.D. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network.

G.E. CalOptima Health and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.

H.F. CalOptima Health shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

I. CalOptima Health shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in section III.I. of this policy and in accordance with CalOptima Health ~~Policy Policies~~ GG.1508: Authorization and Processing of Referrals ~~section~~ Section III.A. and CC.1600 Authorization and Processing of Referrals.

III. PROCEDURE

A. A Provider or Practitioner shall verify a Member’s eligibility as follows:

1. Medi-Cal and Covered California CalOptima Health eligibility: In accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification; and
2. OneCare: Contact the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 and document the Eligibility Verification Confirmation number (EVC).

B. A Provider or Practitioner, including Specialist Physician, shall adhere to the responsibilities outlined in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

C. Authorization Requests

1. A Practitioner or Provider shall request the following authorizations in accordance with this Policy:
 - a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.
 - b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

- c. Request for Retrospective Review subject to the limitations as described in CalOptima Health ~~Policy~~Policies GG.1508: Authorization and Processing of Referrals- and CC.1600 Authorization and Processing of Referrals.
2. ~~A~~For a CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member a Provider or Practitioner shall submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department by:
- a. Mail to:- Attn Utilization Management Department
CalOptima Health
PO Box 11033
Orange CA 92856;
 - b. Facsimile at 714-246-8579; or
 - c. Phone: 1-888-587-8088.
 - d. A contracted Provider may submit a routine, urgent, or retrospective authorization request online via the CalOptima Health Provider Portal. The contracted Provider must upload medical documentation to the CalOptima Health Provider Portal to support the Medical Necessity of the requested services.
3. ~~If~~CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member if the request is urgent, the Provider or Practitioner must:
- a. Specify that the request is urgent on the ARF and fax to 714-338-3137;
 - b. Submit as an urgent request via the CalOptima Health Provider Portal; or
 - c. Notify the CalOptima Health UM Department of the urgent request by telephone.
4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health or the Member's Health Network prior to a Member's admission to inpatient status.
5. A contracted hospital shall notify CalOptima Health or the Member's Health Network of a Member's inpatient admission within twenty-four (24) hours of the admission.
- a. All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.
 - i. A decision will be made on an initial request within seventy-two (72) hours of receipt of the request.
 - ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:
 - a) Additional supporting clinical information is needed.
 - b. Concurrent clinical review shall continue throughout the inpatient stay.

- i. If additional days are required a subsequent decision shall be made within seventy-two (72) hours of request or last covered day.
- ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:
 - a) Additional supporting clinical information is needed.
- c. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

D. Prior Authorization Requests for Post-Stabilization Care Services

1. Medically Necessary Post-Stabilization Care Services from Contracted Providers and Non-Contracted Providers.
 - a. A hospital must submit a Prior Authorization request for Post-Stabilization Care Services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:
 - i. Related to the Emergency Medical Condition; and
 - ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.
 - b. All requests and responses for Post-Stabilization Care Service authorizations are required to be fully documented. Documentation must include but is not limited to:
 - i. The date and time of the request;
 - ii. The name of the health care Provider making the request; and
 - iii. The name of the CalOptima Health staff responding to the request.
 - c. A Prior Authorization request for Medically Necessary Post-Stabilization Care Services shall consist of a phone call from the facility to CalOptima Health Utilization Management Department and include the following information to provide sufficient information to make a decision regarding care ~~within thirty (30) minutes for Medi-Cal;~~
 - i. Identifying information including, Member name, birthdate, CIN, and gender;
 - ii. Name and role of facility clinician requesting Prior Authorization, direct phone number and the name of facility;
 - iii. Nature of the emergency condition that has been stabilized;
 - iv. Medical documentation, to include at a minimum:
 - a) History and physical;
 - b) Vital signs;

- c) Laboratory and/or radiology results;
- d) Any available consultation notes; and
- e) Physician progress notes.
- v. Co-morbid conditions; and
- vi. Medical reason for admission to the hospital including proposed treatment.

- d. For a Member enrolled in ~~the Medi-Cal program~~ Covered California, CalOptima Health shall approve or deny a ~~Provider's~~ Prior Authorization request for Post-Stabilization Care Services within thirty (30) minutes after receipt of request that fully complies with Section III.D.1.b. of this policy. If CalOptima Health fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care Services are deemed approved.
 - i. Notwithstanding Section III.D.1.c. of this Policy, pursuant to section 1300.71.4 of Title 28 of the California Code of Regulations, CalOptima Health may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of Post-Stabilization Care Services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services of the Member's medical condition.
 - ii. In the case where CalOptima Health denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.
- e. For a Member enrolled in ~~the OneCare program~~, CalOptima Health shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within sixty (60) minutes after receipt of request that fully complies with Section III.E.1.b. of this Policy. If CalOptima Health does not respond to such request within sixty (60) minutes, Medically Necessary Post-Stabilization Care Services are considered approved.
- f. CalOptima Health shall pay for Medically Necessary hospital Emergency Services and Post-Stabilization Care Services in accordance with CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible, and MA.3101: Claims Processing.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

- a. For a Member enrolled in Medi-Cal, CalOptima Health shall approve or deny a Prior Authorization request for non-urgent care following an exam in an emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member who has received Emergency Services. If CalOptima Health does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.
- ## 3. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

E. Retrospective Authorization

~~1. A Provider or Practitioner may request retrospective authorization review for Covered Services rendered to a member when circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request. One of the following conditions must apply:~~

~~a. The Member has Other Health Coverage (OHC);~~

~~b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal or OneCare, as applicable, and CalOptima Health eligibility at the time of service; or~~

~~c. The Member's medical condition requires additional, immediate medical need during a planned procedure.~~

2.1. Medical documentation must accompany the retrospective authorization request. ~~A~~For a CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member
a Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member by submitting the following to CalOptima Health's UM Department:

a. Fully completed ARF;

b. Evidence of OHC payment or denial, if applicable;

~~c. Facility services;~~

~~a.c.~~ History and physical;

~~b.d.~~ Discharge summary;

~~e.e.~~ Progress notes;

f. Laboratory results

~~d.g.~~ Physician's orders;

~~e.h.~~ Operative report; if applicable

~~f.i.~~ Emergency Department report, if applicable; and

~~g.j.~~ Outpatient procedure report, if applicable.

~~d.~~ Outpatient professional services;

~~e.k.~~ Diagnosis related to services provided;

f.l. Current Procedural Technology (CPT) ~~or~~ Healthcare Common Procedure Coding System (HCPCS) codes;

~~g.m.~~ Medical justification;

~~h.~~ Progress notes; and

i. ~~Procedure report.~~

~~3.2.~~ CalOptima Health or the Health Network, shall process a request for retrospective authorization within thirty (30) calendar days from receipt of the information that is reasonably necessary to make a determination in accordance with CalOptima Health ~~Policy~~Policies GG.1508: Authorization and Processing of Referrals (~~Attachment A~~), and CC.1600 Authorization and Processing of Referrals.

F. A Provider or Practitioner may request to modify an authorization prior to rendering services by contacting the CalOptima Health UM Department or the Member's Health Network.

~~0.1.~~ CalOptima Health shall process a request for authorization, in accordance with CalOptima Health ~~Policy GG.1508:~~Policies GG.1508: Authorization and Processing of Referrals and CC.1600 Authorization and Processing of Referrals.

~~H.G.~~ CalOptima Health shall process a request for authorization of out-of-network and/or out-of-area services, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

~~H.H.~~ Services Excluded from the Prior Authorization Process

1. No Prior Authorization is required for the following services:

- a. Emergency services
- b. Urgent care visits
- c. Sensitive services (which include family planning)
- d. Sexually transmitted disease services
- e. Elective abortion
- f. Minor consent services
- g. Human Immunodeficiency Virus (HIV) testing
- h. Basic prenatal care services
- i. Routine obstetrics services
- j. Pediatric preventive services, including any recommended routine immunizations
- k. Primary and preventive care services, including ~~any recommended~~ routine immunizations.

l. During a Governor-declared public health emergency, preventive items, immunizations, diagnostic and screening tests, and FDA-authorized therapeutics shall be provided without prior authorization, utilization management, or cost sharing, shall follow January 1, 2025, USPSTF/ACIP baseline, and shall implement any State Department of Public Health modification, supplement, or removal within fifteen (15) business days.

- 1 2. Cancer Biomarker testing services for a Member who meets the following criteria, in
2 accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010:
3 Cancer Biomarker Testing:
4
5 a. Advanced or metastatic stage 3 or 4 cancer; or
6
7 b. Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4
8 cancer.
9
10 c. A Provider or Practitioner shall submit:
11
12 i. For portal authorizations, when biomarker testing is requested, the Provider will attest
13 to the Member having stage 3 or stage 4 cancer and request will be processed the.
14
15 ii. For fax authorizations where biomarker testing is requested, the Provider will attest to
16 the stage 3 and 4 cancer diagnosis on the ARF.
17

18 I. ~~For Covered California, if a Health Network receives a request for authorization for a Transplant~~
19 ~~evaluation:~~

20 ~~I.A. Health Networks – a Health Network receives a request for authorization for a Transplant evaluation:~~

21 ~~1. The Health Network shall notify the Provider to request authorization from CalOptima Health~~
22 ~~and shall forward the request to CalOptima Health Utilization Management Department within~~
23 ~~one (1) working day after receipt.~~

24 ~~2.1. CalOptima Health or a Health Network shall authorize a referral to a transplant program that~~
25 ~~meets DHCS criteria for an evaluation within seventy-two (72) hours of the Member's Primary~~
26 ~~Care Provider (PCP) or specialist identifying the Member as a potential candidate for the MOT~~
27 ~~services and receiving all of the necessary information to make a referral or authorization as~~
28 ~~appropriate in accordance with DHCS APL 21-015: Benefit Standardization and Mandatory~~
29 ~~Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal~~
30 ~~Initiative.~~

31 ~~3.2. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated~~
32 ~~Special Care Center shall complete the evaluation required to determine medical suitability,~~
33 ~~including candidacy and compliance, in order to qualify the Member for a Transplant.~~

34
35 I. For Medi-Cal and OneCare, if a Health Network receives a request for authorization for a
36 Transplant evaluation:

37 1. The Health Network shall notify the Provider to request authorization from CalOptima Health
38 and shall forward the request to CalOptima Health Utilization Management Department within
39 one (1) working day after receipt.

40 2. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated
41 Special Care Center shall complete the evaluation required to determine medical suitability,
42 including candidacy and compliance, in order to qualify the Member for a Transplant.

43 4.3. The Member's Health Network shall immediately notify CalOptima Health upon identification
44 of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center
45 or a Designated Special Care Center or is approved for a Transplant.
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1 **IV. ATTACHMENT(S)**

2
3 Not Applicable

4
5 **V. REFERENCE(S)**

- 6
7 A. CalOptima Health Authorization Request Form (ARF) – Medi-Cal
8 B. CalOptima Health Authorization Request Form (ARF) – Behavioral Health Treatment
9 C. CalOptima Health Authorization Request Form (ARF) – OneCare

10
11 **~~V.I. REFERENCE(S)~~**

- 12
13 ~~A.D.~~ CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
14 ~~B.E.~~ CalOptima Health, Health Network Service Agreement
15 ~~C.F.~~ CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
16 ~~D.G.~~ CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for
17 which CalOptima Health is Financially Responsible
18 ~~E.H.~~ CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model –
19 Coordination with County CCS Program
20 ~~F.I.~~ CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
21 ~~G.J.~~ CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies
22 ~~H.K.~~ CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
23 ~~I.L.~~ CalOptima Health Policy GG.1401: Physician Administered Drug (PAD) Prior Authorization
24 Process
25 ~~J.M.~~ CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical
26 Equipment (DME), Excluding Wheelchairs
27 ~~K.N.~~ CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-
28 Medical
29 ~~L.O.~~ CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
30 P. CalOptima Health Policy CC.1600 Authorization and Processing of Referrals.
31 ~~M.Q.~~ CalOptima Health Policy GG.1510: Member Appeal Process
32 ~~N.R.~~ CalOptima Health Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental,
33 Purchase, and Repair
34 ~~O.S.~~ CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
35 ~~P.T.~~ CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
36 ~~Q.U.~~ CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
37 ~~R.V.~~ CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment
38 (BHT) Services
39 ~~S.W.~~ CalOptima Health Policy MA.3101: Claims Processing
40 ~~T.X.~~ CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination
41 ~~U.Y.~~ CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
42 ~~V.Z.~~ CalOptima Health Utilization Management Program
43 ~~W.AA.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit
44 Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing
45 and Innovating Medi-Cal Initiative
46 ~~X.BB.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker
47 Testing
48 ~~Y.CC.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Authorizations for
49 Post-Stabilization Care Services
50 ~~Z.DD.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization
51 Requirements (Supersedes APLs 18-004 and 16-009)

~~AA-EE~~. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)

~~BB-FF~~. Health and Safety Code, Sections 1363.5 and 1367.01

~~CC-GG~~. Title 22, California Code of Regulations, Sections 51003 and 51536

~~DD-HH~~. Title 28, California Code of Regulations, Section 1300.71.4

~~EE-IL~~. Title 42, United States Code, Section 139u-2(b)(2)(D)

~~FF-JJ~~. Title 42, Code of Federal Regulations, Section 438.404(a) and 438.910(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/28/2021	Department of Health Care Services (DHCS)	Approved as Submitted
08/23/2022	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/18/2024	Department of Health Care Services (DHCS)	File & Use
05/07/2026	Department of Health Care Services (DHCS)	File & Use
09/09/2026	Department of Health Care Services (DHCS)	File & Use

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/1997	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	05/01/1999	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	07/01/2007	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	09/01/2011	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	03/01/2012	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	02/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	03/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	01/01/2016	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2017	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2018	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	03/01/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/03/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	09/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	08/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	04/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	11/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2025	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	05/01/2026	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
<u>Revised</u>		<u>GG.1500</u>	<u>Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers</u>	<u>Covered California Medi-Cal OneCare</u>

IX. GLOSSARY

Term	Definition
Applied Behavior Analysis (ABA)	Refers to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g., aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	For the purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services.
Autism Spectrum Disorder (ASD)	A developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
CalOptima Health	For purposes of this policy, CalOptima Health means CalOptima Health Direct, including CalOptima Health Community Network (CHCN).
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Covered Services	<u>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.</u> <u>Medi-Cal:</u> 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

Term	Definition
	of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 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);

Term	Definition
	10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	<u>Covered California & Medi-Cal</u>: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; 3. Serious dysfunction of any bodily organ or part; or 4. Death <u>OneCare</u>: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could

Term	Definition
	reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	Covered California & Medi-Cal: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1). OneCare: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever comes first.
Medically Necessary or Medical Necessity	<u>Covered California: 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).</u> Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or

Term	Definition
	regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	An individual enrolled in a CalOptima Health program.
Non-Contracted Provider	<u>Covered California: A Provider who is not contracted with CalOptima Health to provide services under the Member's CalOptima Health plan contract.</u> <u>Medi-Cal</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member. <u>OneCare</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Out-of-Area	Outside of the Service Area.
Out-of-Network	<u>Health Network</u>: Outside of the selected Health Network's participating provider network within the Service Area. <u>Provider [CalOptima Health]</u>: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care Services	<u>Covered California: Medically Necessary care provided after an Emergency Medical Condition has been Stabilized as defined in Health & Safety Code §1317.1(j).</u> <u>Medi-Cal</u>: Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition. <u>OneCare</u>: Services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or under some circumstances, to improve or resolve the condition.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	<u>Covered California: 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).</u> <u>Medi-Cal:</u> A formal process requiring a Provider to obtain advanced approval for the amount, duration, and scope of non-emergent Covered Services <u>OneCare:</u> A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	<u>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.</u> <u>Medi-Cal:</u> 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. <u>OneCare:</u> 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.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Psychological Testing	The use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning.
Retrospective Review	The process of determining Medical Necessity after treatment has been given.

Term	Definition
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Provider.

1

For 20261001 BOD Review Only



Policy: GG.1500
Title: **Authorization Instructions for
CalOptima Health Direct and
CalOptima Health Community
Network Providers**

Department: Utilization Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 07/01/1997
Revised Date:

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

I. PURPOSE

To define the process by which a Provider or Practitioner shall obtain authorization for Covered Services for a CalOptima Health Direct (COHD), CalOptima Health Community Network (CHCN) Member, or a Health Network Member including Prior Authorization, Concurrent Review, and Retrospective Review.

II. POLICY

A. A Provider or Practitioner shall request Prior Authorization, Concurrent Review and Retrospective Review for Covered Services listed on the CalOptima Health Prior Authorization Required List, available at www.caloptima.org, in accordance with this Policy, except as provided in CalOptima Health Policies CC.1600: Authorization and Processing of Referrals and GG.1508: Authorization and Processing of Referrals.

1. A Provider or Practitioner requests authorization for elective inpatient services, elective outpatient services, elective ancillary services, and Post-Stabilization Care Services after an emergency admission, prior to rendering such Covered Services to a Member.
2. A Provider or Practitioner may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider's or Practitioner's ability to obtain a Prior Authorization request. A Retrospective Review must meet criteria in Section II.A.2.a and one (1) of the following criteria in Section II.A.2.b:
 - a. When submitted within the appropriate Retrospective submission timeframe:
 - i. For a OneCare Member a request must be made within thirty (30) calendar days after the initial date of service.
 - ii. For a Medi-Cal Member a request must be made within thirty (30) calendar days after the initial date of service.

- 1 iii. For a Covered California Member, a request must be made within thirty (30) calendar
2 days after the initial date of service, and
3
- 4 b. One (1) of the following conditions must apply:
- 5
- 6 i. Coordination of benefits (COB) when the Member has Other Health Coverage (OHC);
7
- 8 ii. The Member's medical condition is such that the Provider or Practitioner is unable to
9 verify the Member's eligibility for Medi-Cal, OneCare or Covered California as
10 applicable, and CalOptima Health eligibility at the time of service; or
11
- 12 iii. The Member's medical condition requires additional, immediate medical need during a
13 planned procedure.
14
- 15 3. A Provider or Practitioner requests authorization for Covered Services rendered to a Member
16 who is retroactively eligible for the CalOptima Health program within thirty (30) calendar days
17 after the Member's retroactive eligibility determination is available in the State of California
18 Beneficiary Eligibility Verification System or California Healthcare Eligibility, Enrollment and
19 Retention System (CalHEERS) for Members enrolled in Covered California.
20
- 21 4. Transplant Services: For a Medi-Cal or OneCare if the Member is enrolled in a Health Network,
22 the Provider shall request authorization for Transplant evaluation services from CalOptima
23 Health.
24
- 25 B. CalOptima Health and its Health Networks shall ensure that clinical decisions made related to
26 coverage or denial of requested services due in whole or in part to Medical Necessity are consistent
27 and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1508:
28 Authorization and Processing of Referrals, GG.1535: Utilization Review Criteria and Guidelines
29 and CC.1600 Authorization and Processing of Referrals.
30
- 31 C. Contracted and Non-Contracted Emergency Service Providers
- 32
- 33 1. The attending emergency physician, or the Provider treating the Member, is responsible for
34 determining when the Member is sufficiently stabilized for transfer or discharge, and that
35 determination is binding on CalOptima Health.
36
- 37 2. Emergency Services are not subject to Prior Authorization by CalOptima Health, and
38 CalOptima Health shall not limit what constitutes an Emergency Medical Condition on the basis
39 of lists of diagnoses or symptoms. CalOptima Health shall follow the standard definition of a
40 Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an
41 emergency.
42
- 43 a. The attending emergency physician, or the Provider treating the Member, is responsible for
44 determining when the Member is sufficiently stabilized for transfer or discharge, and that
45 determination is binding on such Member's assigned Health Network or on CalOptima
46 Health if such Member is a CalOptima Health Direct Member, whichever is applicable.
47
- 48 b. A plan health professional shall be available to the emergency room personnel treating the
49 Member, for consultation and for general communication, in accordance with CalOptima
50 Health Policies GG.1508: Authorization and Processing of Referrals and CC.1600
51 Authorization and Processing of Referrals.
52

- 1 D. A hospital shall notify CalOptima Health within twenty-four (24) hours of a Member's Initial
2 Emergency Encounter in accordance with CalOptima Health Policies GG.1508: Authorization and
3 Processing of Referrals and CC.1600 Authorization and Processing of Referrals. See Section III.D.
4 of this policy for Prior Authorization Requests for Post-Stabilization Care Services for Medically
5 Necessary Post-Stabilization Care Services from Contracted Providers and Non-Contracted
6 Providers.
- 7
- 8 E. A Provider or Practitioner shall obtain authorization for the following services, in accordance with
9 specified CalOptima Health policies:
- 10
- 11 1. Services for a Member who meets California Children's Services (CCS) eligibility criteria, in
12 accordance with CalOptima Health Policy CalOptima Health Policies GG.1508: Authorization
13 and Processing of Referrals and CC.1600 Authorization and Processing of Referrals;
 - 14
 - 15 2. Medical Supplies, in accordance with CalOptima Health Policies GG.1401: Physician
16 Administered Drug (PAD) Prior Authorization Process, GG.1508: Authorization and Processing
17 of Referrals, MA.6101: Coverage Determination, and CC.1600 Authorization and Processing of
18 Referrals;
 - 19
 - 20 3. Disposable incontinence supplies, in accordance with CalOptima Health Policy GG.1114:
21 Authorization for Disposable Incontinence Supplies;
 - 22
 - 23 4. Durable Medical Equipment, in accordance with CalOptima Health Policy GG.1502: Criteria
24 and Authorization for Durable Medical Equipment (DME), Excluding Wheelchairs;
 - 25
 - 26 5. Wheelchair rental, purchase, or repair, in accordance with CalOptima Health Policy GG.1531:
27 Criteria and Authorization for Wheelchair and Seating Equipment;
 - 28
 - 29 6. Non-emergency medical transportation and non-medical transportation, in accordance with
30 CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-
31 Medical;
 - 32
 - 33 7. Hospice services, in accordance with CalOptima Health Policy GG.1503: CalOptima Health
34 Hospice Coverage and Authorization Requirements;
 - 35
 - 36 8. Pharmacy services, in accordance with CalOptima Health Policies GG.1401: Physician
37 Administered Drug (PAD) Prior Authorization Process, and MA.6101: Medicare Part D
38 Coverage Determination; and
 - 39
 - 40 9. Applied Behavioral Analysis (ABA) services and Psychological Testing, in accordance with
41 CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health
42 Treatment (BHT) Services.
 - 43
- 44 C. A Provider or Practitioner may appeal CalOptima Health's utilization management (UM) decision,
45 in accordance with CalOptima Health Policies GG.1510: Member Appeal Process, MA.9003:
46 Standard Pre-Service Appeal, and MA.9004: Expedited Pre-Service Integrated Appeal.
- 47
- 48 D. For services that do not require a Prior Authorization, Providers, including Specialist Physicians,
49 shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network.
50 Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health
51 Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
- 52

1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network.

E. CalOptima Health and its Health Networks shall establish a process to monitor the appropriate utilization of medical care and services delivered to Members and ensure that care is monitored, analyzed, and interventions are implemented upon the identification of under and over utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.

F. CalOptima Health shall ensure the Prior Authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.

1. CalOptima Health shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in section III.I. of this policy and in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals Section III.A, and CC.1600 Authorization and Processing of Referrals.

III. PROCEDURE

A. A Provider or Practitioner shall verify a Member's eligibility as follows:

1. Medi-Cal and Covered California CalOptima Health eligibility: In accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification; and
2. OneCare: Contact the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387 and document the Eligibility Verification Confirmation number (EVC).

B. A Provider or Practitioner, including Specialist Physician, shall adhere to the responsibilities outlined in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.

C. Authorization Requests

1. A Practitioner or Provider shall request the following authorizations in accordance with this Policy:
 - a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.
 - b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.
 - c. Request for Retrospective Review subject to the limitations as described in CalOptima Health Policies GG.1508: Authorization and Processing of Referrals and CC.1600 Authorization and Processing of Referrals.
2. For a CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member a Provider or Practitioner shall submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department by:
 - a. Mail to: Attn Utilization Management Department

CalOptima Health
PO Box 11033
Orange CA 92856;

- b. Facsimile at 714-246-8579; or
 - c. Phone: 1-888-587-8088.
 - d. A contracted Provider may submit a routine, urgent, or retrospective authorization request online via the CalOptima Health Provider Portal. The contracted Provider must upload medical documentation to the CalOptima Health Provider Portal to support the Medical Necessity of the requested services.
3. CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member if the request is urgent, the Provider or Practitioner must:
- a. Specify that the request is urgent on the ARF and fax to 714-338-3137;
 - b. Submit as an urgent request via the CalOptima Health Provider Portal; or
 - c. Notify the CalOptima Health UM Department of the urgent request by telephone.
4. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health or the Member's Health Network prior to a Member's admission to inpatient status.
5. A contracted hospital shall notify CalOptima Health or the Member's Health Network of a Member's inpatient admission within twenty-four (24) hours of the admission.
- a. All initial requests for an inpatient stay will be acknowledged within twenty-four (24) hours of receipt of the request by providing a CalOptima Health tracking number to the facility.
 - i. A decision will be made on an initial request within seventy-two (72) hours of receipt of the request.
 - ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:
 - a) Additional supporting clinical information is needed.
 - b. Concurrent clinical review shall continue throughout the inpatient stay.
 - i. If additional days are required a subsequent decision shall be made within seventy-two (72) hours of request or last covered day.
 - ii. CalOptima Health may extend this time frame by up to fourteen (14) calendar days, under the following condition:
 - a) Additional supporting clinical information is needed.
 - c. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

D. Prior Authorization Requests for Post-Stabilization Care Services

1. Medically Necessary Post-Stabilization Care Services from Contracted Providers and Non-Contracted Providers.

- a. A hospital must submit a Prior Authorization request for Post-Stabilization Care Services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:
 - i. Related to the Emergency Medical Condition; and
 - ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.
- b. All requests and responses for Post-Stabilization Care Service authorizations are required to be fully documented. Documentation must include but is not limited to:
 - i. The date and time of the request;
 - ii. The name of the health care Provider making the request; and
 - iii. The name of the CalOptima Health staff responding to the request.
- c. A Prior Authorization request for Medically Necessary Post-Stabilization Care Services shall consist of a phone call from the facility to CalOptima Health Utilization Management Department and include the following information to provide sufficient information to make a decision regarding care:
 - i. Identifying information including, Member name, birthdate, CIN, and gender;
 - ii. Name and role of facility clinician requesting Prior Authorization, direct phone number and the name of facility;
 - iii. Nature of the emergency condition that has been stabilized;
 - iv. Medical documentation, to include at a minimum:
 - a) History and physical;
 - b) Vital signs;
 - c) Laboratory and/or radiology results;
 - d) Any available consultation notes; and
 - e) Physician progress notes.
 - v. Co-morbid conditions; and
 - vi. Medical reason for admission to the hospital including proposed treatment.
- d. For a Member enrolled in Medi-Cal or Covered California, CalOptima Health shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within

thirty (30) minutes after receipt of request that fully complies with Section III.D.1.b. of this policy. If CalOptima Health fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care Services are deemed approved.

i. Notwithstanding Section III.D.1.c. of this Policy, pursuant to section 1300.71.4 of Title 28 of the California Code of Regulations, CalOptima Health may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of Post-Stabilization Care Services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services of the Member's medical condition.

ii. In the case where CalOptima Health denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

e. For a Member enrolled in OneCare, CalOptima Health shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within sixty (60) minutes after receipt of request that fully complies with Section III.E.1.b. of this Policy. If CalOptima Health does not respond to such request within sixty (60) minutes, Medically Necessary Post-Stabilization Care Services are considered approved.

f. CalOptima Health shall pay for Medically Necessary hospital Emergency Services and Post-Stabilization Care Services in accordance with CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible, and MA.3101: Claims Processing.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

a. For a Member enrolled in Medi-Cal, CalOptima Health shall approve or deny a Prior Authorization request for non-urgent care following an exam in an emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member who has received Emergency Services. If CalOptima Health does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.

3. CalOptima Health staff shall assist the hospital with timely Discharge Planning to facilitate transition for CalOptima Health Direct Members to the most appropriate level of care following facility discharge.

E. Retrospective Authorization

1. Medical documentation must accompany the retrospective authorization request. For a CalOptima Health Direct (COHD) or CalOptima Health Community Network (CHCN) Member a Provider or Practitioner may request retrospective authorization for Covered Services rendered to a Member by submitting the following to CalOptima Health's UM Department:

- a. Fully completed ARF;
- b. Evidence of OHC payment or denial, if applicable;
- c. History and physical

- 1 d. Discharge summary
- 2
- 3 e. Progress notes;
- 4
- 5 f. Laboratory results
- 6
- 7 g. Physician's orders;
- 8
- 9 h. Operative report; if applicable
- 10
- 11 i. Emergency Department report, if applicable; and
- 12
- 13 j. Outpatient procedure report, if applicable.
- 14
- 15 k. Diagnosis related to services provided;
- 16
- 17 l. Current Procedural Technology (CPT) or Healthcare Common Procedure Coding System
- 18 (HCPCS) codes;
- 19
- 20 m. Medical justification;
- 21
- 22 2. CalOptima Health or the Health Network, shall process a request for retrospective authorization
- 23 within thirty (30) calendar days from receipt of the information that is reasonably necessary to
- 24 make a determination in accordance with CalOptima Health Policies GG.1508: Authorization
- 25 and Processing of Referrals and CC.1600 Authorization and Processing of Referrals.
- 26
- 27 F. A Provider or Practitioner may request to modify an authorization prior to rendering services by
- 28 contacting the CalOptima Health UM Department or the Member's Health Network.
- 29
- 30 1. CalOptima Health shall process a request for authorization, in accordance with CalOptima
- 31 Health Policies GG.1508: Authorization and Processing of Referrals and CC.1600
- 32 Authorization and Processing of Referrals.
- 33
- 34 G. CalOptima Health shall process a request for authorization of out-of-network and/or out-of-area
- 35 services, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network
- 36 and Out-of-Area Services.
- 37
- 38 H. Services Excluded from the Prior Authorization Process
- 39
- 40 1. No Prior Authorization is required for the following services:
- 41
- 42 a. Emergency services
- 43
- 44 b. Urgent care visits
- 45
- 46 c. Sensitive services (which include family planning)
- 47
- 48 d. Sexually transmitted disease services
- 49
- 50 e. Elective abortion
- 51
- 52 f. Minor consent services
- 53

- 1 g. Human Immunodeficiency Virus (HIV) testing
- 2
- 3 h. Basic prenatal care services
- 4
- 5 i. Routine obstetrics services
- 6
- 7 j. Pediatric preventive services, including any recommended routine immunizations
- 8
- 9 k. Primary and preventive care services, including routine immunizations.
- 10
- 11 l. During a Governor-declared public health emergency, preventive items, immunizations,
- 12 diagnostic and screening tests, and FDA-authorized therapeutics shall be provided without
- 13 prior authorization, utilization management, or cost sharing, shall follow January 1, 2025,
- 14 USPSTF/ACIP baseline, and shall implement any State Department of Public Health
- 15 modification, supplement, or removal within fifteen (15) business days.
- 16
- 17 2. Cancer Biomarker testing services for a Member who meets the following criteria, in
- 18 accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010:
- 19 Cancer Biomarker Testing:
- 20
- 21 a. Advanced or metastatic stage 3 or 4 cancer; or
- 22
- 23 b. Cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4
- 24 cancer.
- 25
- 26 c. A Provider or Practitioner shall submit:
- 27
- 28 i. For portal authorizations, when biomarker testing is requested, the Provider will attest
- 29 to the Member having stage 3 or stage 4 cancer and request will be processed the.
- 30
- 31 ii. For fax authorizations where biomarker testing is requested, the Provider will attest to
- 32 the stage 3 and 4 cancer diagnosis on the ARF.
- 33
- 34 I. For Covered California, if a Health Network receives a request for authorization for a Transplant
- 35 evaluation:
- 36
- 37 1. Health Networks shall authorize a referral to a transplant program that meets DHCS criteria for
- 38 an evaluation within seventy-two (72) hours of the Member's Primary Care Provider (PCP) or
- 39 specialist identifying the Member as a potential candidate for the MOT services and receiving
- 40 all of the necessary information to make a referral or authorization as appropriate in accordance
- 41 with DHCS APL 21-015: Benefit Standardization and Mandatory Managed Care Enrollment
- 42 Provisions of the California Advancing and Innovating Medi-Cal Initiative.
- 43
- 44 2. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated
- 45 Special Care Center shall complete the evaluation required to determine medical suitability,
- 46 including candidacy and compliance, in order to qualify the Member for a Transplant.
- 47
- 48 J. For Medi-Cal and OneCare, if a Health Network receives a request for authorization for a
- 49 Transplant evaluation:
- 50
- 51 1. The Health Network shall notify the Provider to request authorization from CalOptima Health
- 52 and shall forward the request to CalOptima Health Utilization Management Department within
- 53 one (1) working day after receipt.

2. After receipt of the authorization, the DHCS-approved Transplant Center or the Designated Special Care Center shall complete the evaluation required to determine medical suitability, including candidacy and compliance, in order to qualify the Member for a Transplant.
3. The Member's Health Network shall immediately notify CalOptima Health upon identification of a Member who is listed for a Solid Organ Transplant at a DHCS-approved Transplant Center or a Designated Special Care Center or is approved for a Transplant.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Authorization Request Form (ARF) – Medi-Cal
- B. CalOptima Health Authorization Request Form (ARF) – Behavioral Health Treatment
- C. CalOptima Health Authorization Request Form (ARF) – OneCare
- D. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
- E. CalOptima Health, Health Network Service Agreement
- F. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
- G. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
- H. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole-Child Model – Coordination with County CCS Program
- I. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
- J. CalOptima Health Policy GG.1114: Authorization for Disposable Incontinence Supplies
- K. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
- L. CalOptima Health Policy GG.1401: Physician Administered Drug (PAD) Prior Authorization Process
- M. CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs
- N. CalOptima Health Policy GG.1505: Transportation, Emergency, Non-Emergency, and Non-Medical
- O. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
- P. CalOptima Health Policy CC.1600 Authorization and Processing of Referrals.
- Q. CalOptima Health Policy GG.1510: Member Appeal Process
- R. CalOptima Health Policy GG.1531: Criteria and Authorization Process for Wheelchair Rental, Purchase, and Repair
- S. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
- T. CalOptima Health Policy GG.1535: Utilization Review Criteria and Guidelines
- U. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
- V. CalOptima Health Policy GG.1548: Authorization and Monitoring of Behavioral Health Treatment (BHT) Services
- W. CalOptima Health Policy MA.3101: Claims Processing
- X. CalOptima Health Policy MA.6101: Medicare Part D Coverage Determination
- Y. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
- Z. CalOptima Health Utilization Management Program
- AA. 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
- BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing

- 1 CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Authorizations for
2 Post-Stabilization Care Services
- 3 DD. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization
4 Requirements (Supersedes APLs 18-004 and 16-009)
- 5 EE. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed
6 Care Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)
- 7 FF. Health and Safety Code, Sections 1363.5 and 1367.01
- 8 GG. Title 22, California Code of Regulations, Sections 51003 and 51536
- 9 HH. Title 28, California Code of Regulations, Section 1300.71.4
- 10 II. Title 42, United States Code, Section 139u-2(b)(2)(D)
- 11 JJ. Title 42, Code of Federal Regulations, Section 438.404(a) and 438.910(d)

12 VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2016	Department of Health Care Services (DHCS)	Approved as Submitted
04/28/2021	Department of Health Care Services (DHCS)	Approved as Submitted
08/23/2022	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
04/18/2024	Department of Health Care Services (DHCS)	File & Use
05/07/2026	Department of Health Care Services (DHCS)	File & Use
09/09/2026	Department of Health Care Services (DHCS)	File & Use

15 VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

16 VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/1997	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	05/01/1999	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	07/01/2007	GG.1500	Authorization Instructions for CalOptima Direct Providers	Medi-Cal
Revised	09/01/2011	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	03/01/2012	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Care Providers	Medi-Cal
Revised	02/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	03/01/2015	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal
Revised	01/01/2016	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2017	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	03/01/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/03/2021	GG.1500	Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers	Medi-Cal OneCare Connect
Revised	06/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	09/01/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	08/01/2023	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	04/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	11/01/2024	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	07/01/2025	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised	05/01/2026	GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Medi-Cal OneCare
Revised		GG.1500	Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers	Covered California Medi-Cal OneCare

1 IX. GLOSSARY

2

Term	Definition
Applied Behavior Analysis (ABA)	Refers to the use of behavioral learning principles (i.e. behavior-consequence paradigm) to produce changes in behavior, specifically the development of skills in areas of need (e.g. language) and the reduction in maladaptive behaviors (e.g. aggression, self-injury). ABA therapy may be comprehensive in nature, teaching adaptive techniques to address multiple behavioral and functional concerns, or may be problem-focused and targeted towards addressing specifically identified problematic behaviors (e.g., aggression). (MCG Behavioral Health 21st Edition)
Authorized Representative	For the purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services.
Autism Spectrum Disorder (ASD)	A developmental disability originating in the early development period and affecting social communication and behavior, which has been diagnosed in accordance with the Diagnostic and Statistical Manual, 5th Edition (DSM-5). ASD also includes diagnoses of Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specific (PDD-NOS), and Asperger Disorder that were made using DSM-IV criteria.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
CalOptima Health	For purposes of this policy, CalOptima Health means CalOptima Health Direct, including CalOptima Health Community Network (CHCN).
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Covered Services	<u>Covered California:</u> 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. <u>Medi-Cal:</u> 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

Term	Definition
	of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 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);

Term	Definition
	10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	<u>Covered California & Medi-Cal</u>: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; 3. Serious dysfunction of any bodily organ or part; or 4. Death <u>OneCare</u>: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could

Term	Definition
	reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	<u>Covered California & Medi-Cal</u>: Inpatient and outpatient Covered Services that are furnished by a qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition, as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1). <u>OneCare</u>: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever comes first.
Medically Necessary or Medical Necessity	<u>Covered California</u>: 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). <u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or

Term	Definition
	regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	An individual enrolled in a CalOptima Health program.
Non-Contracted Provider	<u>Covered California</u>: A Provider who is not contracted with CalOptima Health to provide services under the Member's CalOptima Health plan contract. <u>Medi-Cal</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member. <u>OneCare</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Out-of-Area	Outside of the Service Area.
Out-of-Network	<u>Health Network</u>: Outside of the selected Health Network's participating provider network within the Service Area. <u>Provider [CalOptima Health]</u>: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care Services	<u>Covered California</u>: Medically Necessary care provided after an Emergency Medical Condition has been Stabilized as defined in Health & Safety Code §1317.1(j). <u>Medi-Cal</u>: Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition. <u>OneCare</u>: Services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or under some circumstances, to improve or resolve the condition.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	<u>Covered California:</u> 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). <u>Medi-Cal:</u> A formal process requiring a Provider to obtain advanced approval for the amount, duration, and scope of non-emergent Covered Services <u>OneCare:</u> A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	<u>Covered California:</u> A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal:</u> 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. <u>OneCare:</u> 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.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.
Psychological Testing	The use of standardized assessment tools to gather information relevant to a member's intellectual and psychological functioning. Psychological testing can be used to determine differential diagnosis and assess overall cognitive functioning related to a member's mental health or substance use status. Test results may have important implications for treatment planning.
Retrospective Review	The process of determining Medical Necessity after treatment has been given.

Term	Definition
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a Primary Care Provider.

1

For 20261001 BOD Review Only



Policy: GG.1508
Title: **Authorization and Processing of Referrals**
Department: Utilization Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/1996

Revised Date:

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

I. PURPOSE

This policy establishes the procedure by which CalOptima Health and its Health Networks shall process a request for Prior Authorization, Concurrent Review, and Retrospective Review of Covered Services for a Member.

II. POLICY

A. CalOptima Health and its Health Networks shall process requests for Prior Authorization, Concurrent Review, and Retrospective Review within the timeframes specified in this Policy. CalOptima Health and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.

B. ~~For Members enrolled in OneCare,~~ CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied.

1. Confirm the process of diagnoses or other medical criteria that are in the basis for coverage determinations for the specific item or service;
2. Basic benefits item or service is Medically Necessary; or
3. Supplemental benefits service or benefit is clinically appropriate.

C. ~~For Members enrolled in OneCare,~~ CalOptima Health or a Health Network, as applicable, shall accept an Organization Determination request from a Member or Member's Authorized Representative and shall not redirect the Member or Member's Authorized Representative to the Provider office to make such request.

1. If a ~~OneCare~~ Health Network Member calls CalOptima Health before contacting the Health Network regarding an authorization, CalOptima Health shall transfer such calls to the appropriate Health Network Customer Service line for assistance.

D. CalOptima Health and its Health Networks shall follow the applicable Timeframes for Decisions and Notifications ~~Table,~~ as set forth in ~~Attachments~~ reference A (Timeframes for Medi-Cal Service

Decisions and Notifications) and B (Timeframes for OneCare Service Decisions and Notifications) of this Policy, for all requested services, whether in- or out-of-network, as well as CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

- E. CalOptima Health and its Health Networks shall ensure that a clinical decision is made related to coverage or denial of requested services due in whole or in part to Medical Necessity and are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, and GG.1541: Utilization Management Delegation.
1. Decisions to deny services cannot be solely based on requested codes being listed as non-benefits (i.e., in the Medi-Cal Treatment and Authorization (TAR) and Non-Benefit list of codes), and other reasons for the denial must be included in the NOA denial letter (i.e., services were determined to be not Medically Necessary and/or did not meet other criteria considered).
- F. With respect to the Whole Child Model (WCM) program, CalOptima Health and its Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as California Department of Health Care Services (DHCS) guidance, including, but not limited to, All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima Health and the Health Networks shall:
1. Use all current and applicable California Children's Services (CCS) Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS Numbered Letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.
 2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.
- G. CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
- H. CalOptima Health and its Health Networks must notify network providers Providers of all services that require prior authorization, concurrent authorization or retrospective authorization.
- I. CalOptima Health and the Health Networks shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage. CalOptima Health and the Health Networks do not reward Practitioners or other individuals for issuing denial for coverage, care, or services. CalOptima Health and the Health Networks do not provide financial incentives to utilization management UM decision-makers to encourage decisions that result in underutilization.
- J. CalOptima Health and the Health Networks shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in Section III.A. of this Policy.
- K. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-

Network and in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services.

2. For Health Network Members, a Provider, including a Specialist Physician, shall follow the Health Network's authorization process.

L. Lactation Consultation Exception for Medi-Cal Members: Notwithstanding Sections II.J and II.K, pregnant and postpartum Members may access professional lactation consultation services without Prior Authorization and without a referral. CalOptima Health and its Health Networks shall provide Medically Necessary lactation visits during pregnancy and through twelve (12) months postpartum, with no limit on the number of Medically Necessary visits. Access may be provided in person, home-based, or through Telehealth, as clinically appropriate.

L.M. A Provider or Practitioner may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider or Practitioner's ability to obtain a Prior Authorization request. A retrospective review must meet criteria in Section II.M.1.a and ~~when~~ one (1) of the following ~~conditions apply~~ criteria in Section II.M.1.b.

1. When submitted within the appropriate Retrospective submission timeframe:

- a. For a OneCare Member a request must be made within thirty (30) calendar days after the initial date of service.
- b. For a Medi-Cal Member ~~The~~ a request must be made within thirty (30) calendar days after the initial date of service.

2. One (1) of the following conditions must apply:

- a. Coordination of benefits (COB) when the Member has Other Health Coverage (OHC); ~~or~~
- b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, or OneCare, as applicable, and CalOptima Health eligibility at the time of service; or
- c. The ~~Member's Medical~~ Member's medical condition requires additional, immediate medical need during a planned procedure.

~~a. Retrospective submission timeframe:~~

- ~~a. For a OneCare Member as long as such a request is made within sixty (60) calendar days after the initial date of service.~~
- ~~b. For a Medi-Cal Member as long as such a request is made within a reasonable established time limit, not to exceed sixty (60) calendar days from the date of service.~~

M.N. CalOptima Health and ~~its~~ Health Network shall ensure that all contracted Providers ~~and non-contracting Specialist Physicians and Providers~~ are informed of the Prior Authorization and Referral process at the time of ~~Referral~~ contracting.

O. CalOptima Health and its Health Networks shall make information about Prior Authorizations for items and services, excluding drugs, accessible to Providers no later than one (1) business day after receipt of a Prior Authorization request and shall update such accessible information no later than one (1) business day after any status change. Accessible information shall include the Prior

Authorization status, the date approved or denied, the date or circumstance under which the Prior Authorization ends, the items and services approved, the specific reason for denial when denied, and related structured administrative and clinical documentation submitted by a Provider related to the Prior Authorization. Such information shall remain accessible for the duration that the authorization is active and for at least one (1) year after the Prior Authorization's last status change.

~~N.P.~~ CalOptima Health and its Health Networks that are responsible for ~~utilization management~~ UM of hospital services shall have a plan health professional or a contracting, qualified, and licensed physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization Care Services, to coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

~~Q.Q.~~ CalOptima Health and its Health Networks shall provide coverage and payment, for hospital Emergency Services and Post Stabilization Care Services necessary to determine the presence or absence of an Emergency Medical Condition, and if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member's condition regardless of whether or not the request is from a contracted Provider, Non-Contracted Provider or Out-of-Network, as specified in Section III.D, E, and G of this Policy.

~~P.R.~~ If a Member exhausts ~~his or her~~ their Medicare benefits as provided under the OneCare Program, and at the request of the Health Network under a shared risk contract, CalOptima Health shall authorize Covered Services in accordance with this Policy or other applicable CalOptima Health policies and procedures.

~~Q.S.~~ CalOptima Health and its Health Networks shall maintain a system for tracking and monitoring all Referrals for Provider and Member-requested ~~(OneCare Members only)~~ health care services and supplies requiring Prior Authorization as follows:

1. Referral turnaround time for issuing a determination;
2. Criteria used in making the determination;
3. If denied, deferred, or modified, a copy of the Notice of Action (NOA); and
4. Specific services and supplies approved, denied, deferred, or modified, including classifying non-medical necessity denials.

T. For Prior Authorizations for items and services, excluding drugs, CalOptima Health and its Health Networks shall make the following information accessible to the Member, the Member's Authorized Representative, and the requesting Provider no later than one (1) business day after receipt of the Prior Authorization request:

1. Prior Authorization status;
2. Date the Prior Authorization was approved, if approved;
3. Date or circumstance under which the Prior Authorization ends;
4. Items and services approved; Related structured and unstructured administrative and clinical documentation submitted by the Provider pertaining to Prior Authorization, subject to applicable privacy, identity verification, and disclosure requirements.

- 1 U. CalOptima Health and its Health Networks shall update the accessible Prior Authorization
2 information described in Section II.R no later than one (1) business day after any status change.
3
- 4 V. CalOptima Health and its Health Networks shall continue to make the Prior Authorization
5 information described in Section II.R. accessible for the duration that the authorization is active and
6 for at least one (1) year after the Prior Authorization's last status change.
7
- 8 W. Beginning January 1, 2026, CalOptima Health shall make Prior Authorization metrics publicly
9 accessible by posting them on the CalOptima Health website no later than March 31 of each year for
10 the previous calendar year. The public posting shall be reported at the plan level and shall include
11 all items and services requiring Prior Authorization, excluding drugs. At a minimum, the public
12 posting shall include:
13
- 14 1. A list of all items and services that require Prior Authorization;
15 2. The percentage of standard Prior Authorization requests that were approved;
16
17 3. The percentage of standard Prior Authorization requests that were denied, aggregated for all
18 items and services;
19
20 4. The percentage of standard Prior Authorization requests that were approved after appeal,
21 aggregated for all items and services;
22
23 5. The percentage of Prior Authorization requests for which the timeframe for review was
24 extended, and the request was approved, aggregated for all items and services;
25
26 6. The percentage of expedited Prior Authorization requests that were approved, aggregated for all
27 items and services;
28
29 7. The percentage of expedited Prior Authorization requests that were denied, aggregated for all
30 items and services;
31
32 8. The average and median time between submission of a request and a determination for standard
33 Prior Authorizations, aggregated for all items and services; and
34
35 9. The average and median time between submission of a request and a decision for expedited
36 Prior Authorizations, aggregated for all items and services.
37
- 38 X. CalOptima Health and its Health Networks shall maintain the data necessary to support this annual
39 public posting.
40
- 41 Y. Religious Health Institution
42
- 43 1. For OneCare Members, CalOptima Health and its Health Networks must treat Religious
44 Nonmedical Health Care Institutions (RNHCIs) as an in-network benefit, in accordance with 42
45 CFR §422.112(a)(1)(iii).
46
47 2. CalOptima Health and its Health Networks will arrange for and cover any Medically Necessary,
48 covered benefit outside the Provider network at in-network cost sharing, when an in-network
49 Provider is either unavailable or inadequate to meet the Member's medical needs.
50

51 **III. PROCEDURE**

52 **A. Services Excluded from the Prior Authorization Process**

53
54

1. For the Medi-Cal and OneCare programs, the following services do not require Prior Authorization:
 - a. Emergency Services or emergency care
 - i. CalOptima Health and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
 - ii. CalOptima Health and its Health Networks shall follow the standard definition of a Prudent Layperson, acting reasonably, to determine that the presenting complaint might be an emergency.
 - iii. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on such Member's assigned Health Network or on CalOptima Health if such Member is a CalOptima Health Direct Member, whichever is applicable.
 - b. Preventive and primary care services, including recommended routine immunizations;
 - c. Basic prenatal care;
 - d. Family Planning Services:
 - i. Health education and counseling necessary to make informed choices and to understand contraceptive methods;
 - ii. Limited history and physical examination for family planning services;
 - iii. Laboratory tests, if medically indicated, as part of the decision-making process for selecting a method of contraception;
 - iv. Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated, during one (1) visit;
 - v. Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and Referral for treatment;
 - vi. Provision of contraceptive pills, devices, and supplies;
 - vii. Follow-up care for complications associated with contraceptive methods issued by a family planning Provider or Practitioner;
 - viii. Tubal ligation;
 - ix. Vasectomies; and
 - x. Pregnancy testing and counseling.
 - e. Routine obstetrical services; and
 - f. Elective abortions. *Non-emergency inpatient hospitalization for the performance of an abortion may require prior authorization.

- 1
- 2 i. CalOptima Health and its Health Networks shall cover abortion services, as well as
- 3 directly related medical services and supplies incidental or preliminary to an abortion.
- 4
- 5 ii. CalOptima Health and its Health Networks shall not impose annual or lifetime limits on
- 6 the coverage of outpatient abortion services.
- 7
- 8 g. Cancer Biomarker testing services for a Member who meets the following criteria, in
- 9 accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-
- 10 010: Cancer Biomarker Testing:
- 11
- 12 i. Advanced or metastatic stage three (3) or four (4) cancer; or
- 13
- 14 ii. Cancer progression or recurrence in the Member with advanced or metastatic stage
- 15 three (3) or stage four (4) cancer.
- 16
- 17 iii. For the CalOptima Health Direct and CalOptima Health Community Network
- 18 programs, a Provider or Practitioner shall submit:
- 19
- 20 a) For portal authorizations, when biomarker testing is requested, the Provider will
- 21 attest to the Member having stage three (3) or stage four (4) cancer and the request
- 22 will be processed.
- 23
- 24 b) For fax authorizations where biomarker testing is requested, the Provider will attest
- 25 to the stage three (3) and stage four (4) cancer diagnosis on the Authorization
- 26 Request Form (ARF).
- 27

28 ~~For the OneCare program, in~~

29 ~~2.1 addition to the services identified in Section III.A.1. of this Policy, the following services~~

30 ~~do not require Prior Authorization:~~

31

32 ~~a. Services for Emergency Medical Conditions, including emergency Behavioral Health~~

33 ~~Care;~~

34

35 ~~b.a. Urgent Care sought outside of the service area of Orange County, California;~~

36

37 ~~c.a. Urgent Care under unusual and extraordinary circumstances provided in the service~~

38 ~~area of Orange County, California when the contracted medical provider is unavailable~~

39 ~~or inaccessible; and~~

40

41 ~~d.a. Out of area renal dialysis services.~~

42

43 ~~3.2.~~ For the Medi-Cal Program, in addition to the services identified in Section III.A.1. of this

44 policy, the following services do not require Prior Authorization:

45

- 46 a. Minor Consent Services: The following Minor Consent Services provided to a CalOptima
- 47 Health Medi-Cal Member ~~less than twenty-one (21) years under the age of age~~ eighteen (18)
- 48 do not require parental consent or Prior Authorization. Minor Consent Services ~~are Covered~~
- 49 Services include treatment of a sensitive nature related to the following:
- 50

51 i. Under the age of twelve (12) for pregnancy and pregnancy related services;

52

53 ii. Sexual assault services, including rape;

54

1 iii. Family Planning, including termination of pregnancy *Non-emergency inpatient
2 hospitalization for the performance of an abortion may require prior authorization;

3
4 iv. Age twelve (12) and older;

5
6 a) Drug or alcohol abuse ~~for a Member twelve (12) years of age or older;~~

7
8 b) Pregnancy and pregnancy related services;

9
10 c) Family Planning, including termination of pregnancy *Non-emergency inpatient
11 hospitalization for the performance of an abortion may require prior authorization;

12
13 d) Sexually transmitted diseases (STDs) or HIV/AIDS ~~for a Member twelve (12) years~~
14 ~~of age or older; and;~~

15
16 e) Sexual assault services, including rape;

17
18 f) Infectious, contagious, or communicable disease diagnosis and treatment;

19
20 ~~e)g)~~ Non-Specialty Mental Health Services (NSMHS) for children ages twelve (12) and
21 over who are deemed mature enough by the attending Professional Person to
22 participate intelligently in their health ~~care~~ pursuant to Family Code Section
23 6924.

24
25 h) Intimate partner violence services; and

26
27 ~~h)i)~~ Initial mental health assessments; ~~and;~~

28
29 4.3. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.

30
31 4. In addition to the services identified in Section III.A.1. of this Policy, the following services
32 do not require Prior Authorization:

33
34 a. Services for Emergency Medical Conditions, including emergency Behavioral Health
35 Care;

36
37 b. Urgent Care sought outside of the service area of Orange County, California;

38
39 c. Urgent Care under unusual and extraordinary circumstances provided in the service
40 area of Orange County, California when the contracted medical provider is unavailable
41 or inaccessible; and

42
43 d. Out-of-area renal dialysis services.

44
45 **B. Responsibilities of Primary Care Provider (PCP) and Specialist Physician**

- 46
47 1. A PCP is required to maintain twenty-four (24) hour access for the Member, including
48 availability for response to ~~emergency~~ emergencies and urgent questions from the Member in
49 accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition,
50 Role, and Responsibilities. When possible, the PCP shall evaluate and counsel the Member and
51 direct the Member to the most appropriate level of service based on the Member's condition.
52
53 2. All services shall be provided in the manner and time frames set forth in CalOptima Health
54 Policy GG.1113: Specialty Practitioner Responsibilities.

3. Member Eligibility Verification

- a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima Health identification card, or shall perform an eligibility verification using CalOptima Health's Provider Portal at www.caloptima.org.
- b. Prior Authorization does not guarantee eligibility at the time services are rendered.
- c. For Medi-Cal Members, a Provider or Practitioner shall verify eligibility at the time the services are provided, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

C. Authorization Requests

1. For a CalOptima Health Direct and Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers:
 - a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.
 - b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.
 - c. Request for Retrospective Review subject to the limitations described in Section II.L. of this Policy.

~~2. For a Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with the Health Network's authorization policy:~~

- ~~a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.~~
- ~~b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.~~
- ~~c. Request for Retrospective Review subject to the limitations described in Section II.L. of this policy.~~

~~3.2.~~ An Urgent Authorization Request may be submitted if a routine authorization timeframe will be detrimental to a Member's life or health, ~~jeopardize~~jeopardizing the Member's ability to regain maximum function, or may result in loss of life, limb, or other major body function. Such request is required to be decided within seventy-two (72) hours or as soon as the Member's health condition requires.

~~4.3.~~ A hospital must submit the request for Prior Authorization and obtain approval from CalOptima Health or a Health Network, as applicable, for scheduled inpatient procedures prior to a Member's admission to inpatient status.

~~5.4.~~ All CalOptima Health and Health Network authorization requests must include clinical records that validate the need for the requested item or service.

1
2 D. Outreach for Additional Information Needed to Make Coverage Decisions.
3

- 4 1. If CalOptima Health or the Health Network does not have sufficient information to make a
5 coverage decision on a Prior Authorization, Concurrent Review, or Retrospective Review
6 request, it shall make reasonable and diligent efforts to obtain the necessary information,
7 including medical records and other pertinent clinical documentation, within the applicable
8 timeframe.
9
10 2. Whenever possible, outreach for missing information shall be directed to the requesting or
11 treating Provider or Practitioner. At a minimum, one (1) attempt to obtain the additional
12 information shall be made within the applicable timeframe.
13
14 3. Outreach may be made by telephone, fax, email, mail, or any other available method to obtain
15 the information timely, and multiple methods may be used when feasible. Outreach efforts shall
16 be documented, including the information requested, the date and time of the attempt, the
17 person or entity contacted, the method of outreach, and any information received. If the
18 necessary information is not received within the applicable adjudication timeframe, CalOptima
19 Health or the Health Network shall make the coverage decision based on the information
20 available.
21

22 D.E. Hospital Notification of Emergency Services
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- 24 1. A hospital shall notify CalOptima Health or the Member's Health Network, as applicable,
25 within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification
26 system is implemented, a hospital shall use best efforts to provide such notice within twenty-
27 four (24) hours of the Member's presentation to the emergency department for outpatient
28 Emergency Services.
29
30 2. If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima
31 Health or the Member's Health Network shall be made the following business day, or the time
32 Member identity is known, or would have been known with the exercise of reasonable
33 diligence.
34

35 E.F. E. Prior Authorization Request (Post-Stabilization Care Services)
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- 37 1. Medically Necessary Post-Stabilization Care Services from Contracted Providers and Non-
38 Contracted Providers
39
40 a. A hospital must request a Prior Authorization for Post-Stabilization Care Services when a
41 Member who has received Emergency Services for an Emergency Medical Condition is
42 determined to have reached medical stability, but requires additional, Medically Necessary
43 inpatient Covered Services that are:
44
45 i. Related to the Emergency Medical Condition; and
46
47 ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.
48
49 b. All requests and responses to a Post Stabilization Care Service request are required to be
50 fully documented. Documentation shall include but is not limited to;
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52 i. The date and time of the request;
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54 ii. The name of the health care Provider making the request; and

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- iii. The name of the CalOptima Health or Health Network staff responding to the request.
 - c. A Prior Authorization request for Medically Necessary Post-Stabilization Care Services shall consist of a phone call from the facility to CalOptima Health or a Health Network's Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare:
 - i. Identifying information including Member name, birthdate, CIN, and gender;
 - ii. Name and role of facility clinician requesting prior authorization, their direct phone number and the name of facility;
 - iii. Nature of the emergency condition that has been stabilized;
 - iv. Medical documentation to include at a minimum:
 - a) History and physical;
 - b) Vital signs; and
 - c) Laboratory and/or radiology results.
 - v. Co-morbid conditions; and
 - vi. Medical reason for admission to the hospital including proposed treatment.
 - d. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request for Medically Necessary Post-Stabilization Care Services in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.
 - e. For a Health Network Member enrolled in the Medi-Cal program, the Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within thirty (30) minutes after receipt of request that fully complies with Section III.E.1.a-c of this Policy. If the Health Network fails to approve or deny such request within thirty (30) minutes, Medically Necessary Post-Stabilization Care Services are deemed approved.
 - i. Notwithstanding Section III.E.1.d. of this Policy, pursuant to Section 1300.71.4 of Title 28 of the California Code of Regulations, the Health Network may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of Post-Stabilization Care Services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.
 - ii. In the case where the Health Network denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.

- 1 f. For a Health Network Member enrolled in the OneCare program, a Health Network shall
2 approve or deny a Provider's Prior Authorization request for Post-Stabilization Care
3 Services within sixty (60) minutes after receipt of request that fully complies with Section
4 III.E.1a-c of this Policy. If the Health Network does not respond to such request within
5 sixty (60) minutes, Medically Necessary Post-Stabilization Care Services are considered
6 approved.
7
- 8 g. CalOptima Health and its Health Networks are also financially responsible for Post-
9 Stabilization Care Services in the event that CalOptima Health or the Health Network:
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- 11 i. Did not respond to a request for pre-approval within the timeframe allotted (Medi-Cal
12 within thirty (30) minutes, OneCare within sixty (60) minutes);
13
- 14 ii. Could not be contacted; or
15
- 16 iii. Could not reach an agreement with the treating Provider concerning the Member's care
17 and CalOptima Health or the Health Network physician was not available for
18 consultation.
19
- 20 h. In the case where CalOptima Health or a Health Network and the treating Provider cannot
21 reach an agreement concerning the Member's care and the CalOptima Health or Health
22 Network physician is not available for consultation, CalOptima Health or the Health
23 Network shall give the treating Provider the opportunity to consult with a CalOptima Health
24 or Health Network physician and the treating Provider may continue with care of the
25 Member until a CalOptima Health or the Health Network physician is reached or one (1) of
26 the following criteria is met:
27
- 28 i. CalOptima or the Health Network physician with privileges at the treating Provider's
29 hospital assumes responsibility for the Member's care;
30
- 31 ii. CalOptima Health or the Health Network physician assumes responsibility for the
32 Member's care through transfer;
33
- 34 iii. CalOptima Health or the Health Network and the treating Provider reach an agreement
35 concerning the Member's care; or
36
- 37 iv. The Member is discharged.
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40 2. Medically Necessary Non-Urgent Care Following Emergency Room Exam
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- 42 a. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima
43 Health shall process a Prior Authorization request from a non-contracted Provider for
44 Medically Necessary non-urgent care following an exam in the emergency room in
45 accordance with CalOptima Health Policy GG.1500: Authorization Instructions for
46 CalOptima Health Direct and CalOptima Health Community Network Providers.
47
- 48 b. For a Health Network Member enrolled in the Medi-Cal program, a Health Network shall
49 approve or deny a Prior Authorization request for non-urgent care following an exam in the
50 emergency room within thirty (30) minutes after receipt of such request from a non-
51 contracted Provider on behalf of a Member, who has received Emergency Services. If the
52 Health Network does not respond to such request within the required timeframe, Medically
53 Necessary non-urgent care is deemed approved.
54

3. Health Network staff shall assist the hospital with timely Discharge Planning to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

F. Second Medical Opinions

1. A Member or the Member's Authorized Representative has the right to request a second opinion.
2. For Medi-Cal, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's Customer Service Department (714-246-8500 or toll-free at 888-587-8088, TDD/TTY: 711), or the Member's Health Network.
3. For OneCare, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's OneCare Customer Service Department (714-246-8711 or toll-free at 877-412-2734, TDD/TTY: 711), or the Member's Health Network.
4. CalOptima Health or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.
5. A Member may receive a second opinion from an in-network Provider at no cost. If an in-network Provider is not available, CalOptima Health or their Health Network shall make arrangements for the Member to obtain a second opinion from an out-of-network Provider at no cost.
6. A Member may receive a third opinion, at no cost to a Member, if there is a disparity between the initial and second opinion.

G. Out-of-Network Services

1. CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
2. CalOptima Health or a Health Network shall adequately and timely cover out-of-network services, for as long as CalOptima Health or the Health Network is unable to provide the services within the network. CalOptima Health or the Health Network shall process out-of-network service requests, as specified in the Timeframes for Decisions and Notifications Tables.
3. All requests requiring Prior Authorization shall require the requestor to submit a fully completed Authorization Request Form to CalOptima Health or the Health Network, along with medical justification sufficient to make a determination and the physician signature. CalOptima Health or the Health Network, shall process the request, as specified in the Timeframes for Decisions and Notifications Tables.
4. CalOptima Health or a Health Network shall follow the Timeframes for Decisions and Notifications Tables for all requested services, whether in or out of the network.

1 5. CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an
2 identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141:
3 CalOptima Health Provider Contracts.
4

5 6. CalOptima Health or a Health Network shall provide continued access as follows:
6

- 7 a. For newly enrolled Medi-Cal beneficiaries, for up to twelve (12) months, to an out-of-
8 network Provider with whom the Member has had an ongoing relationship if there are no
9 quality-of-care issues with the Provider and the Provider accepts contracted or Medi-Cal
10 rates in accordance with CalOptima Health Policy GG.1325: Continuity of Care for
11 Members Transitioning into CalOptima Health Services.
12
13 b. For Members eligible with the California Children's Services (CCS) Program and
14 transitioned into the WCM program, for up to twelve (12) months, to an out-of-network
15 CCS-paneled Provider, specialized or customized durable medical equipment provider,
16 currently prescribed medication, and public health nurse, in accordance with CalOptima
17 Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima
18 Health Services, and GG.1330: Case Management – California Children's Services
19 Program/Whole Child Model.
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21 H. Denials, Deferrals, Dismissals, Terminations and Modifications of Prior Authorization Requests
22

23 1. -In-Network Specialist Physician-
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- 25 a. CalOptima Health or a Health Network may redirect specialty care Prior Authorization
26 requests to an in-network Specialist Physician under the following conditions:
27
28 a. All modification, denial, dismissal, termination and notification requirements are
29 followed pursuant to regulation requirements; and
30
31 b. The in-network Specialist Physician is selected based on the following:
32
33 i. A demonstrated ability to provide the services requested;
34
35 ii. Prolific experience providing the services requested;
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37 iii. Volume of the requested care previously provided;
38
39 iv. An existing relationship with CalOptima Health or the Health Network, as
40 applicable;
41
42 v. A proven ability to maintain adequate Member access;
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44 vi. A proven ability to provide care coordination;
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46 vii. No existing issues related to continuity of care or Tertiary service needs; and
47
48 viii. For Members eligible with the CCS Program and transitioned into the WCM
49 program, a CCS-paneled provider qualified to treat the CCS-Eligible Condition of
50 the CCS child or youth, in accordance with CCS Program rules and regulations.
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52 2. Consultation with Board-Certified Specialist-
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- 1 a. CalOptima Health or a Health Network may consult with a Board-Certified specialist if the
2 Prior Authorization request is out of the scope of practice of the physician reviewer.
3
4 i. A CalOptima Health or Health Network Medical Director shall forward a request for
5 review by a Board-Certified specialist to the Prior Authorization manager or Designee
6 for appropriateness;
7
8 ii. ~~The~~ For a CalOptima Health Member, the Prior Authorization manager or Designee
9 shall forward the request to a contracted external review agency electronically for
10 review; and
11
12 iii. Upon receipt of the recommendation of the external review agency, the CalOptima
13 Health Medical Director or Health Network shall conduct the final review and
14 determination.
15
16 b. The UMC shall maintain a list of Board-Certified specialists and will be reviewed annually
17 by the Quality Improvement Committee (QIC).
18
19 3. Tertiary Care
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21 a. CalOptima Health or a Health Network shall authorize Tertiary Care Services when a
22 Member requires testing or treatment that is otherwise not available at a non-Tertiary level
23 of care.
24
25 b. CalOptima Health or a Health Network shall only authorize Tertiary Care services under the
26 following circumstances:
27
28 i. A Member requires testing or treatment that is otherwise not available at a non-Tertiary
29 level of care;
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31 ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty
32 services as part of a complex, coordinated plan of care;
33
34 iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise
35 not safe to perform at a non-Tertiary level of care;
36
37 iv. A Member or Provider requires a referral for experimental or investigational procedures
38 not available in-network and may do so directly through CalOptima Health; and
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40 v. There is no quality-of-care issues for the Provider.

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42 4. Utilization Management (UM) Decision-
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- 44 a. CalOptima Health and its Health Networks shall ensure the following:
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46 i. Requested health care services may be approved by UM staff who are not qualified
47 health care professionals only when:
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49 a) The UM staff is under the supervision of an appropriately licensed health
50 professional;
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52 b) There are explicit UM criteria; and
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54 c) No clinical judgement is required.

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- ii. Requested health care services which require the use of clinical judgement shall be approved by licensed health care professionals.
 - iii. Decisions to deny or to authorize an amount, duration, or scope less than the requested health care services shall be made by a qualified medical director with a current and unrestricted license to practice in California or other health care professional with appropriate clinical expertise in treating the condition and disease, including knowledge of Medicare and Medi-Cal coverage criteria.
 - a) Only a qualified, licensed ~~-physician~~ or other qualified health care professional, as appropriate, shall deny or authorize an amount, duration, or scope less than the requested health care services based in whole or in part on Medical Necessity for any non-behavioral healthcare services.
 - b) Only a qualified, licensed ~~-physician~~ or appropriate behavioral healthcare practitioner as appropriate shall review and issue denials for Behavioral Health Care services for Medical Necessity or benefit coverage related to a Medi-Cal Member's behavioral health benefits; and
 - c) Only a qualified, licensed ~~-physician~~ or qualified, licensed clinical pharmacist shall review and approve, defer, modify or deny prior authorizations for pharmaceutical services.
 - d) Only qualified, licensed health care professionals supervise review decisions requiring Prior Authorization, including service reductions, and a qualified, licensed ~~-physician~~ shall review all denials of a request for health care services based in whole or in part on Medical Necessity.

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4.5 Notification of UM Decision

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- a. CalOptima Health and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. In addition, for OneCare, CalOptima Health and its Health Networks shall ensure compliance with the notification requirements set forth in CalOptima Health Policy MA.6042: Integrated Organization Determinations.
 - b. If Medical Necessity criteria are not met, and review by a CalOptima Health or Health Network qualified licensed physician does not find the Member requires the requested inpatient level of care and Prior Authorization request is denied, delayed, modified, or alternative treatment is recommended, CalOptima Health or a Health Network shall notify the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action.
 - i. CalOptima Health or the Health Network must provide auxiliary aids and services to a family member, friend, or associate of a Member if required by the ADA, including if the individual is identified as the Members' Authorized Representative, or is someone with whom it is appropriate for CalOptima Health or the Health Network to communicate.
 - ii. Communication needs ~~of~~ must be accommodated for all qualified Members with disabilities, including Authorized Representatives, and be prepared to facilitate alternate

format requests for Braille, audio format, large print (no less than 20-point Arial font), and acceptable electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

- c. For routine (non-urgent) authorization requests, if CalOptima Health or a Health Network does not take action by approving, denying, deferring, or modifying services, on a written request for Prior Authorization of Covered Services within ~~fourteen (14) calendar days after receipt~~ the timeframe specified in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, such request shall be deemed denied by default and a notification of denial for the requested service shall be sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. Availability of CalOptima Health UM Staff and Services

1. CalOptima Health's UM Department shall provide Members or potential Members access to information about the UM process, and the process for authorizing care, in the Medi-Cal Member Handbook, and OneCare Evidence of Coverage available in-print and on the CalOptima Health website at www.caloptima.org.
2. CalOptima Health's UM Department shall provide Practitioners with access to information about the UM process, and the process for authorizing care, in the CalOptima Health Provider Manual, available on the CalOptima Health website at www.caloptima.org.
3. UM staff shall be available for inbound calls including toll free and collect calls, ~~regarding~~ UM issues during CalOptima Health normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima Health's Customer Service Department and routed to appropriate UM staff.
 - a. UM staff shall provide a toll-free number ~~+~~ and accept collect calls regarding UM issues.
 - b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.
 - c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
 - d. UM staff shall be accessible to callers who have questions about the UM process.
 - e. UM qualified, licensed physicians shall be available to answer denial determination questions during normal business hours and after hours calls regarding UM issues. During business hours, calls shall be directed to the UM Department and transferred to the appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.
 - f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.
4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). Communications received after normal business hours are returned on the next business day.

Communications received after midnight on Monday-Friday are responded to on the same business day.

5. CalOptima Health or its Health Network shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic and Services (CalOptima Health is able to receive and send TDD/TTY messages and has a separate phone number for receiving TDD/TTY messages.).
 6. CalOptima Health for its Health Network shall provide language assistance services free of charge to Members. CalOptima Health shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
 7. CalOptima Health shall send a CalOptima Health Medi-Cal Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Health Policy DD.2005: Member-Informing Materials Requirements. The handbook will note the availability of UM staff in regard to UM issues and will include the Customer Service Department phone number and the TDD/TTY phone number.
 8. Annually, CalOptima Health shall inform Medi-Cal Members of the availability of the CalOptima Health Member Handbook/Evidence of Coverage.
 9. Annually, CalOptima Health shall send via U.S. Mail the OneCare Evidence of Coverage, for OneCare Members.
- J. Failure of a Health Network or CalOptima Health department to comply with CalOptima Health's authorization policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action which may include, but not be limited to, education and training on CalOptima Health's authorization process and reports to the Utilization Management Committee (UMC), Delegation Oversight Committee (DOC), and/or the Compliance Committee.
1. Continued non-compliance may lead to the issuance of a Corrective Action Plan (CAP) and/or Sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

- A. Timeframes for Medi-Cal Service Decisions and Notifications
- B. Timeframes for OneCare Service Decisions and Notifications

V. REFERENCE(S)

- A. California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)
- ~~A.B.~~ CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
- ~~B.C.~~ CalOptima Health Contract with the Department of Health Care Services (DHCS) for Dual Eligible Special Needs Plans (D-SNPs)
- ~~C.A. Medicare Managed Care Manual "Benefits and Beneficiary Protections", Section 20.3 Section 20.4 and Section 20.5.2~~
- D. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes

- E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- F. CalOptima Health, Health Network Service Agreement
- G. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
- H. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
- I. CalOptima Health Policy DD.2005: Member-Informing Materials Requirements
- J. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
- K. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
- L. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
- M. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
- N. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
- O. CalOptima Health Policy GG.1330: Case Management – California Children’s Services Program/Whole Child Model
- P. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers
- Q. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
- R. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
- S. CalOptima Health Policy HH.2002: Sanctions
- T. CalOptima Health Policy HH.2005: Corrective Action Plan
- U. CalOptima Health Utilization Management Program
- V. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and “Your Rights” Templates (Revised 08/31/2022)
- ~~W. Department of Health Care Services All Plan Letter (APL) 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)~~
- ~~X.W.~~ Department of Health Care Services (DHCS) All- Plan Letter (APL) 22-010: Cancer Biomarker Testing
- ~~Y.X.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care Services
- ~~Z.Y.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion and Directly Related Medical Services and Supplies (Supersedes APL 22-022)
- ~~AA.Z.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
- ~~BB.AA.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-019: Consent to Outpatient Mental Health Treatment or Counseling
- ~~CC.BB.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 25-016: Alternative Format Selection For Members With Visual Impairments (Supersedes APL 22-002)
- ~~CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)~~
- ~~DD. Family Code, Section 6924~~
- ~~DD.A. California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)~~
- EE. Health and Safety Code, Sections 1363.5 and 1367.01
- ~~FF.A. Family Code, Section 6924~~
- ~~GG.FF.~~ Medi-Cal Member Handbook
- ~~GG. Medicare Managed Care Manual “Benefits and Beneficiary Protections”, Section 20.3 Section 20.4 and Section 20.5.2~~
- ~~HH. National Committee for Quality Assurance (NCQA) HP Standards and Guidelines, MED 9 Element D, Factor 3~~
- ~~II. OneCare Evidence of Coverage~~
- ~~JJ. Title 28, California Code of Regulations (CCR), §1300.71.4~~
- ~~HH.A. OneCare Evidence of Coverage~~
- ~~H.A. Title 28, California Code of Regulations (CCR), §1300.71.4~~

~~KK. Title 42, Code of Federal Regulations (CFR), §§ 422.112(a)(1)(iii), 422.113 (b)(2)(ii), (b)(3) and (c), 422.138(a) and (b)(1-3), 422.562 (a)(4), 422.566 (a)(d), 422.590 (h), 422.629 (k)(3) and (4), 423.562(a)(5), 423.566 (a)(d), 423.590 (f), 438.114 (a), 438.404(a) and (c)(5), and 438.910(d)~~
~~KK.A. National Committee for Quality Assurance (NCQA) HP Standards and Guidelines, MED 9 Element D, Factor 3~~

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/02/2009	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/17/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2018	Department of Health Care Services (DHCS)	Approved as Submitted
04/19/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
08/17/2022	Department of Health Care Services (DHCS)	File and Use
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/22/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/19/2023	Department of Health Care Services (DHCS)	File and Use
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
05/08/2025	Department of Health Care Services (DHCS)	Approved as Submitted
12/22/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/1998	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	05/01/1999	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	07/01/2000	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	10/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	06/01/2007	GG.1508	Authorization and Processing of Referrals	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2011	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	02/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	11/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2013	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2014	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Correction	05/10/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	03/01/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/03/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	09/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	01/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	08/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	12/31/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	02/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	04/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	06/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	12/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	02/01/2026	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	03/01/2026	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	03/01/2026	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
<u>Revised</u>		<u>GG.1508</u>	<u>Authorization and Processing of Referrals</u>	<u>Medi-Cal</u> <u>OneCare</u>

For 20261001 BOD Review ONLY

1 IX. GLOSSARY

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Term	Definition
Authorized Representative	For purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services
Autism Spectrum Disorder (ASD)	A developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Health Direct	A direct health care program operated by that includes both COHD-Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

Term	Definition
Comprehensive Diagnostic Evaluation	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Continuity of Care	<u>Medi-Cal</u>: Services provided to a Member rendered by an Out-of-Network Provider with whom the Member has a pre-existing provider relationship. <u>OneCare</u>: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; and 5. Appropriate discharge planning; and Timely placement at different levels of care including hospital, skilled nursing, and home health care.
Covered Services	<u>Medi-Cal</u>: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as

Term	Definition
	specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.

Term	Definition
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	<u>Medi-Cal</u>: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; and/or 3. Serious dysfunction of any bodily organ or part. <u>OneCare</u>: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	<u>Medi-Cal</u>: Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. <u>OneCare</u>: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first.
Medically Necessary or Medical Necessity	<u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic

Term	Definition
	Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dl(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	An individual enrolled in a CalOptima Health program.
Minor Consent Services	Those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations: 1. Sexual assault, including rape; 2. Drug or alcohol abuse for minors 12 years of age or older; 3. Pregnancy; 4. Family planning; 5. Sexually transmitted diseases (STDs) in minors 12 years of age or older; 6. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and 7. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or Child abuse.
Non-Contracted Provider	<u>Medi-Cal</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member. <u>OneCare</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Non-Specialty Mental Health Services (NSMHS)	Mild-to-moderate mental health coverage requirements of CalOptima for Medi-Cal Members that are delivered via managed care and include the following: 1. Mental health evaluation and treatment, including individual, group and family psychotherapy 2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition

Term	Definition
	3. Outpatient services for purposes of monitoring drug therapy 4. Psychiatric consultation 5. Outpatient laboratory, drugs, supplies and supplements
Organization Determination	Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.
Out-of-Area	Outside of the Service Area
Out-of-Network	<u>Health Network</u>: Outside of the selected Health Network's participating provider network within the Service Area <u>Provider [CalOptima Health]</u>: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care Services	Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 31.438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	<u>Medi-Cal</u>: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services <u>OneCare</u>: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Professional Person	A person authorized to provide services under Family Code § 6924, including registered psychologists, psychology trainees, associate clinical social workers, social work interns, and psychiatrists.
Provider	<u>Medi-Cal</u>: 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. <u>OneCare</u>: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.

Term	Definition
Qualified Licensed Physician	For purposes of this policy, if CalOptima Health or a Health Network expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the request shall be reviewed by a qualified licensed physician with a current and unrestricted license to practice in California or other appropriate health professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medi-Cal coverage criteria, before issuing the Coverage Decision Letter (OD) or Notice of Action (NOA).
Referral	The process of a Provider directing a Member to another Provider for care and /or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Tertiary Care	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.



Policy: GG.1508
Title: **Authorization and Processing of Referrals**
Department: Utilization Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/1996

Revised Date:

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

I. PURPOSE

This policy establishes the procedure by which CalOptima Health and its Health Networks shall process a request for Prior Authorization, Concurrent Review, and Retrospective Review of Covered Services for a Member.

II. POLICY

- A. CalOptima Health and its Health Networks shall process requests for Prior Authorization, Concurrent Review, and Retrospective Review within the timeframes specified in this Policy. CalOptima Health and its Health Networks shall maintain appropriate communication with the Member, the Member's Authorized Representative, and Practitioner or Provider, throughout the Prior Authorization process to facilitate delivery of appropriate services.
- B. CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied.
1. Confirm the process of diagnoses or other medical criteria that are in the basis for coverage determinations for the specific item or service;
 2. Basic benefits item or service is Medically Necessary; or
 3. Supplemental benefits service or benefit is clinically appropriate.
- C. CalOptima Health or a Health Network, as applicable, shall accept an Organization Determination request from a Member or Member's Authorized Representative and shall not redirect the Member or Member's Authorized Representative to the Provider office to make such request.
1. If a Health Network Member calls CalOptima Health before contacting the Health Network regarding an authorization, CalOptima Health shall transfer such calls to the appropriate Health Network Customer Service line for assistance.
- D. CalOptima Health and its Health Networks shall follow the applicable Timeframes for Decisions and Notifications as set forth in reference A (Timeframes for Medi-Cal Service Decisions and Notifications) and B (Timeframes for OneCare Service Decisions and Notifications) of this Policy,

for all requested services, whether in- or out-of-network, as well as CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

- E. CalOptima Health and its Health Networks shall ensure that a clinical decision is made related to coverage or denial of requested services due in whole or in part to Medical Necessity and are consistent and based upon sound medical evidence, in accordance with CalOptima Health Policies GG.1535: Utilization Review Criteria and Guidelines, and GG.1541: Utilization Management Delegation.
1. Decisions to deny services cannot be solely based on requested codes being listed as non-benefits (i.e., in the Medi-Cal Treatment and Authorization (TAR) and Non-Benefit list of codes), and reasons for the denial must be included in the denial letter (i.e., services were determined to be not Medically Necessary and/or did not meet other criteria considered).
- F. With respect to the Whole Child Model (WCM) program, CalOptima Health and its Health Networks shall ensure compliance with applicable statutory, regulatory, and contractual requirements, as well as California Department of Health Care Services (DHCS) guidance, including, but not limited to, All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program, or any superseding APL. Without limiting the foregoing, CalOptima Health and the Health Networks shall:
1. Use all current and applicable California Children's Services (CCS) Program guidelines, including CCS Program regulations, CCS Program information notices, and CCS Numbered Letters in developing criteria for use by their respective medical director or the equivalent, and other care management staff.
 2. Use evidenced-based guidelines or treatment protocols that are medically appropriate given the Member's CCS-Eligible Condition in cases in which applicable CCS clinical guidelines do not exist.
- G. CalOptima Health and its Health Networks shall ensure the authorization process for Covered Services is consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
- H. CalOptima Health and its Health Networks must notify network Providers of all services that require prior authorization, concurrent authorization or retrospective authorization.
- I. CalOptima Health and the Health Networks shall make utilization management (UM) decisions based only on appropriateness of care and service, and existence of coverage. CalOptima Health and the Health Networks do not reward Practitioners or other individuals for issuing denial for coverage, care, or services. CalOptima Health and the Health Networks do not provide financial incentives to UM decision-makers to encourage decisions that result in underutilization.
- J. CalOptima Health and the Health Networks shall not require a Provider or Practitioner to request Prior Authorization for Covered Services specified in Section III.A. of this Policy.
- K. For services that do not require a Prior Authorization, Providers, including Specialist Physicians, shall refer the Member to a contracted Provider, unless such Provider is unavailable in-network. Referrals to an out-of-network Provider shall be processed in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
1. For Sensitive Services, Members may access any Provider, including those who are out-of-network, as outlined in CalOptima Health Policy GG.1118: Family Planning Services, Out-of-

Network and in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion Services.

2. For Health Network Members, a Provider, including a Specialist Physician, shall follow the Health Network's authorization process.
- L. Lactation Consultation Exception for Medi-Cal Members: Notwithstanding Sections II.J and II.K, pregnant and postpartum Members may access professional lactation consultation services without Prior Authorization and without a referral. CalOptima Health and its Health Networks shall provide Medically Necessary lactation visits during pregnancy and through twelve (12) months postpartum, with no limit on the number of Medically Necessary visits. Access may be provided in person, home-based, or through Telehealth, as clinically appropriate.
- M. A Provider or Practitioner may request a retrospective authorization review for Covered Services rendered to a Member when extenuating circumstances prevent the Provider or Practitioner's ability to obtain a Prior Authorization request. A retrospective review must meet criteria in Section II.M.1.a and one (1) of the following criteria in Section II.M.1.b.
 1. When submitted within the appropriate Retrospective submission timeframe:
 - a. For a OneCare Member a request must be made within thirty (30) calendar days after the initial date of service.
 - b. For a Medi-Cal Member a request must be made within thirty (30) calendar days after the initial date of service.
 2. One (1) of the following conditions must apply:
 - a. Coordination of benefits (COB) when the Member has Other Health Coverage (OHC); or
 - b. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, or OneCare, as applicable, and CalOptima Health eligibility at the time of service; or
 - c. The Member's medical condition requires additional, immediate medical need during a planned procedure.
- N. CalOptima Health and its Health Network shall ensure that all contracted Providers are informed of the Prior Authorization and Referral process at the time of contracting.
- O. CalOptima Health and its Health Networks shall make information about Prior Authorizations for items and services, excluding drugs, accessible to Providers no later than one (1) business day after receipt of a Prior Authorization request and shall update such accessible information no later than one (1) business day after any status change. Accessible information shall include the Prior Authorization status, the date approved or denied, the date or circumstance under which the Prior Authorization ends, the items and services approved, the specific reason for denial when denied, and related structured administrative and clinical documentation submitted by a Provider related to the Prior Authorization. Such information shall remain accessible for the duration that the authorization is active and for at least one (1) year after the Prior Authorization's last status change.
- P. CalOptima Health and its Health Networks that are responsible for UM of hospital services shall have a plan health professional or a contracting, qualified, and licensed physician available twenty-four (24) hours a day, seven (7) days a week to authorize Medically Necessary Post-Stabilization

Care Services, to coordinate the transfer of stabilized Members in an emergency department if necessary, and for general communication with emergency room personnel.

- Q. CalOptima Health and its Health Networks shall provide coverage and payment, for hospital Emergency Services and Post Stabilization Care Services necessary to determine the presence or absence of an Emergency Medical Condition, and if an Emergency Medical Condition exists, for all services Medically Necessary to stabilize the Member's condition regardless of whether or not the request is from a contracted Provider, Non-Contracted Provider or Out-of- Network, as specified in Section III.D, E, and G of this Policy.
- R. If a Member exhausts their Medicare benefits as provided under the OneCare Program, and at the request of the Health Network under a shared risk contract, CalOptima Health shall authorize Covered Services in accordance with this Policy or other applicable CalOptima Health policies and procedures.
- S. CalOptima Health and its Health Networks shall maintain a system for tracking and monitoring all Referrals for Provider and Member-requested health care services and supplies requiring Prior Authorization as follows:
1. Referral turnaround time for issuing a determination;
 2. Criteria used in making the determination;
 3. If denied, deferred, or modified, a copy of the Notice of Action (NOA); and
 4. Specific services and supplies approved, denied, deferred, or modified, including classifying non-medical necessity denials.
- T. For Prior Authorizations for items and services, excluding drugs, CalOptima Health and its Health Networks shall make the following information accessible to the Member, the Member's Authorized Representative, and the requesting Provider no later than one (1) business day after receipt of the Prior Authorization request:
1. Prior Authorization status;
 2. Date the Prior Authorization was approved, if approved;
 3. Date or circumstance under which the Prior Authorization ends;
 4. Items and services approved; Related structured and unstructured administrative and clinical documentation submitted by the Provider pertaining to Prior Authorization, subject to applicable privacy, identity verification, and disclosure requirements.
- U. CalOptima Health and its Health Networks shall update the accessible Prior Authorization information described in Section II.R no later than one (1) business day after any status change.
- V. CalOptima Health and its Health Networks shall continue to make the Prior Authorization information described in Section II.R. accessible for the duration that the authorization is active and for at least one (1) year after the Prior Authorization's last status change.
- W. Beginning January 1, 2026, CalOptima Health shall make Prior Authorization metrics publicly accessible by posting them on the CalOptima Health website no later than March 31 of each year for the previous calendar year. The public posting shall be reported at the plan level and shall include

all items and services requiring Prior Authorization, excluding drugs. At a minimum, the public posting shall include:

1. A list of all items and services that require Prior Authorization;
 2. The percentage of standard Prior Authorization requests that were approved;
 3. The percentage of standard Prior Authorization requests that were denied, aggregated for all items and services;
 4. The percentage of standard Prior Authorization requests that were approved after appeal, aggregated for all items and services;
 5. The percentage of Prior Authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services;
 6. The percentage of expedited Prior Authorization requests that were approved, aggregated for all items and services;
 7. The percentage of expedited Prior Authorization requests that were denied, aggregated for all items and services;
 8. The average and median time between submission of a request and a determination for standard Prior Authorizations, aggregated for all items and services; and
 9. The average and median time between submission of a request and a decision for expedited Prior Authorizations, aggregated for all items and services.
- X. CalOptima Health and its Health Networks shall maintain the data necessary to support this annual public posting.
- Y. Religious Health Institution
1. For OneCare Members, CalOptima Health and its Health Networks must treat Religious Nonmedical Health Care Institutions (RNHCIs) as an in-network benefit, in accordance with 42 CFR §422.112(a)(1)(iii).
 2. CalOptima Health and its Health Networks will arrange for and cover any Medically Necessary, covered benefit outside the Provider network at in-network cost sharing, when an in-network Provider is either unavailable or inadequate to meet the Member's medical needs.

III. PROCEDURE

A. Services Excluded from the Prior Authorization Process

1. For the Medi-Cal and OneCare programs, the following services do not require Prior Authorization:
 - a. Emergency Services or emergency care
 - i. CalOptima Health and its Health Networks shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

- 1 ii. CalOptima Health and its Health Networks shall follow the standard definition of a
2 Prudent Layperson, acting reasonably, to determine that the presenting complaint might
3 be an emergency.
4
5 iii. The attending emergency physician, or the Provider treating the Member, is responsible
6 for determining when the Member is sufficiently stabilized for transfer or discharge,
7 and that determination is binding on such Member's assigned Health Network or on
8 CalOptima Health if such Member is a CalOptima Health Direct Member, whichever is
9 applicable.
10
11 b. Preventive and primary care services, including recommended routine immunizations;
12
13 c. Basic prenatal care;
14
15 d. Family Planning Services:
16
17 i. Health education and counseling necessary to make informed choices and to understand
18 contraceptive methods;
19
20 ii. Limited history and physical examination for family planning services;
21
22 iii. Laboratory tests, if medically indicated, as part of the decision-making process for
23 selecting a method of contraception;
24
25 iv. Diagnosis and treatment of sexually transmitted diseases (STDs), if medically indicated,
26 during one (1) visit;
27
28 v. Screening, testing, and counseling of at-risk individuals for human immunodeficiency
29 virus (HIV) and Referral for treatment;
30
31 vi. Provision of contraceptive pills, devices, and supplies;
32
33 vii. Follow-up care for complications associated with contraceptive methods issued by a
34 family planning Provider or Practitioner;
35
36 viii. Tubal ligation;
37
38 ix. Vasectomies; and
39
40 x. Pregnancy testing and counseling.
41
42 e. Routine obstetrical services; and
43
44 f. Elective abortions. *Non-emergency inpatient hospitalization for the performance of an
45 abortion may require prior authorization.
46
47 i. CalOptima Health and its Health Networks shall cover abortion services, as well as
48 directly related medical services and supplies incidental or preliminary to an abortion.
49
50 ii. CalOptima Health and its Health Networks shall not impose annual or lifetime limits on
51 the coverage of outpatient abortion services.
52

- 1 g. Cancer Biomarker testing services for a Member who meets the following criteria, in
2 accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 22-
3 010: Cancer Biomarker Testing:
4
5 i. Advanced or metastatic stage three (3) or four (4) cancer; or
6
7 ii. Cancer progression or recurrence in the Member with advanced or metastatic stage
8 three (3) or stage four (4) cancer.
9
10 iii. For the CalOptima Health Direct and CalOptima Health Community Network
11 programs, a Provider or Practitioner shall submit:
12
13 a) For portal authorizations, when biomarker testing is requested, the Provider will
14 attest to the Member having stage three (3) or stage four (4) cancer and the request
15 will be processed.
16
17 b) For fax authorizations where biomarker testing is requested, the Provider will attest
18 to the stage three (3) and stage four (4) cancer diagnosis on the Authorization
19 Request Form (ARF).
20
21 2. For the Medi-Cal Program, in addition to the services identified in Section III.A.1. of this
22 policy, the following services do not require Prior Authorization:
23
24 a. Minor Consent Services: The following Minor Consent Services provided to a CalOptima
25 Health Medi-Cal Member under the age of eighteen (18) do not require parental consent or
26 Prior Authorization. Minor Consent Services include treatment of the following:
27
28 i. Under the age of twelve (12) for pregnancy and pregnancy related services;
29
30 ii. Sexual assault services, including rape;
31
32 iii. Family Planning, including termination of pregnancy *Non-emergency inpatient
33 hospitalization for the performance of an abortion may require prior authorization;
34
35 iv. Age twelve (12) and older;
36
37 a) Drug or alcohol abuse;
38
39 b) Pregnancy and pregnancy related services;
40
41 c) Family Planning, including termination of pregnancy *Non-emergency inpatient
42 hospitalization for the performance of an abortion may require prior authorization;
43
44 d) Sexually transmitted diseases (STDs) or HIV/AIDS;
45
46 e) Sexual assault services, including rape;
47
48 f) Infectious, contagious, or communicable disease diagnosis and treatment;
49
50 g) Non-Specialty Mental Health Services (NSMHS) for children ages twelve (12) and
51 over who are deemed mature enough by the attending Professional Person to
52 participate intelligently in their health care pursuant to Family Code Section 6924.
53
54 h) Intimate partner violence services; and

- i) Initial mental health assessments.
3. The Comprehensive Diagnostic Evaluation for assessment of Autism Spectrum Disorder.
4. In addition to the services identified in Section III.A.1. of this Policy, the following services do not require Prior Authorization:
 - a. Services for Emergency Medical Conditions, including emergency Behavioral Health Care;
 - b. Urgent Care sought outside of the service area of Orange County, California;
 - c. Urgent Care under unusual and extraordinary circumstances provided in the service area of Orange County, California when the contracted medical provider is unavailable or inaccessible; and
 - d. Out-of-area renal dialysis services.

B. Responsibilities of Primary Care Provider (PCP) and Specialist Physician

1. A PCP is required to maintain twenty-four (24) hour access for the Member, including availability for response to emergencies and urgent questions from the Member in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities. When possible, the PCP shall evaluate and counsel the Member and direct the Member to the most appropriate level of service based on the Member's condition.
2. All services shall be provided in the manner and time frames set forth in CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities.
3. Member Eligibility Verification
 - a. A Provider or Practitioner shall request basic information from a Member when providing services, including access to the Member's Medi-Cal Beneficiary Identification Card (BIC), Medicare identification card, or CalOptima Health identification card, or shall perform an eligibility verification using CalOptima Health's Provider Portal at www.caloptima.org.
 - b. Prior Authorization does not guarantee eligibility at the time services are rendered.
 - c. For Medi-Cal Members, a Provider or Practitioner shall verify eligibility at the time the services are provided, in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification.

C. Authorization Requests

1. For a CalOptima Health Direct and Health Network Member, a Practitioner or Provider shall request the following authorizations in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers:
 - a. Request for Prior Authorization for Covered Services and/or supplies, including an Urgent Authorization Request.
 - b. Request for Concurrent Review for services needing authorization, but which have begun without Prior Authorization in place, and are continuing.

- 1
2 c. Request for Retrospective Review subject to the limitations described in Section II.L. of this
3 Policy.
4
- 5 2. An Urgent Authorization Request may be submitted if a routine authorization timeframe will be
6 detrimental to a Member's life or health, jeopardizing the Member's ability to regain maximum
7 function, or may result in loss of life, limb, or other major body function. Such request is
8 required to be decided within seventy-two (72) hours or as soon as the Member's health
9 condition requires.
10
- 11 3. A hospital must submit the request for Prior Authorization and obtain approval from CalOptima
12 Health or a Health Network, as applicable, for scheduled inpatient procedures prior to a
13 Member's admission to inpatient status.
14
- 15 4. All CalOptima Health and Health Network authorization requests must include clinical records
16 that validate the need for the requested item or service.
17
- 18 D. Outreach for Additional Information Needed to Make Coverage Decisions.
19
- 20 1. If CalOptima Health or the Health Network does not have sufficient information to make a
21 coverage decision on a Prior Authorization, Concurrent Review, or Retrospective Review
22 request, it shall make reasonable and diligent efforts to obtain the necessary information,
23 including medical records and other pertinent clinical documentation, within the applicable
24 timeframe.
25
- 26 2. Whenever possible, outreach for missing information shall be directed to the requesting or
27 treating Provider or Practitioner. At a minimum, one (1) attempt to obtain the additional
28 information shall be made within the applicable timeframe.
29
- 30 3. Outreach may be made by telephone, fax, email, mail, or any other available method to obtain
31 the information timely, and multiple methods may be used when feasible. Outreach efforts shall
32 be documented, including the information requested, the date and time of the attempt, the
33 person or entity contacted, the method of outreach, and any information received. If the
34 necessary information is not received within the applicable adjudication timeframe, CalOptima
35 Health or the Health Network shall make the coverage decision based on the information
36 available.
37
- 38 E. Hospital Notification of Emergency Services
39
- 40 1. A hospital shall notify CalOptima Health or the Member's Health Network, as applicable,
41 within twenty-four (24) hours of a Member's Initial Emergency Encounter. Until a notification
42 system is implemented, a hospital shall use best efforts to provide such notice within twenty-
43 four (24) hours of the Member's presentation to the emergency department for outpatient
44 Emergency Services.
45
- 46 2. If the Initial Emergency Encounter occurs on a holiday or weekend, notification to CalOptima
47 Health or the Member's Health Network shall be made the following business day, or the time
48 Member identity is known, or would have been known with the exercise of reasonable
49 diligence.
50
- 51 F. Prior Authorization Request (Post-Stabilization Care Services)
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- 53 1. Medically Necessary Post-Stabilization Care Services from Contracted Providers and Non-
54 Contracted Providers

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- a. A hospital must request a Prior Authorization for Post-Stabilization Care Services when a Member who has received Emergency Services for an Emergency Medical Condition is determined to have reached medical stability, but requires additional, Medically Necessary inpatient Covered Services that are:
 - i. Related to the Emergency Medical Condition; and
 - ii. Provided to maintain, improve, or resolve the Member's stabilized medical condition.
 - b. All requests and responses to a Post Stabilization Care Service request are required to be fully documented. Documentation shall include but is not limited to;
 - i. The date and time of the request;
 - ii. The name of the health care Provider making the request; and
 - iii. The name of the CalOptima Health or Health Network staff responding to the request.
 - c. A Prior Authorization request for Medically Necessary Post-Stabilization Care Services shall consist of a phone call from the facility to CalOptima Health or a Health Network's Utilization Management Department clinician and include the following information to provide sufficient information to make a decision regarding care within thirty (30) minutes for Medi-Cal and sixty (60) minutes for OneCare:
 - i. Identifying information including Member name, birthdate, CIN, and gender;
 - ii. Name and role of facility clinician requesting prior authorization, their direct phone number and the name of facility;
 - iii. Nature of the emergency condition that has been stabilized;
 - iv. Medical documentation to include at a minimum:
 - a) History and physical;
 - b) Vital signs; and
 - c) Laboratory and/or radiology results.
 - v. Co-morbid conditions; and
 - vi. Medical reason for admission to the hospital including proposed treatment.
 - d. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request for Medically Necessary Post-Stabilization Care Services in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.
 - e. For a Health Network Member enrolled in the Medi-Cal program, the Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within thirty (30) minutes after receipt of request that fully complies with Section III.E.1.a-c of this Policy. If the Health Network fails to approve or deny such request within

thirty (30) minutes, Medically Necessary Post-Stabilization Care Services are deemed approved.

- i. Notwithstanding Section III.E.1.d. of this Policy, pursuant to Section 1300.71.4 of Title 28 of the California Code of Regulations, the Health Network may notify the Provider of the denial of such request prior to the commencement of the delivery or during the continuation of the delivery of Post-Stabilization Care Services, provided that the disruption of such services (taking into account the time necessary to effect the Member's transfer or discharge) does not have an adverse impact on the efficacy of such services or the Member's medical condition.
- ii. In the case where the Health Network denies such request and informs the Provider of its decision to transfer the Member to another Provider, the Health Network shall effectuate the transfer of the Member as soon as possible.
- f. For a Health Network Member enrolled in the OneCare program, a Health Network shall approve or deny a Provider's Prior Authorization request for Post-Stabilization Care Services within sixty (60) minutes after receipt of request that fully complies with Section III.E.1a-c of this Policy. If the Health Network does not respond to such request within sixty (60) minutes, Medically Necessary Post-Stabilization Care Services are considered approved.
- g. CalOptima Health and its Health Networks are also financially responsible for Post-Stabilization Care Services in the event that CalOptima Health or the Health Network:
 - i. Did not respond to a request for pre-approval within the timeframe allotted (Medi-Cal within thirty (30) minutes, OneCare within sixty (60) minutes);
 - ii. Could not be contacted; or
 - iii. Could not reach an agreement with the treating Provider concerning the Member's care and CalOptima Health or the Health Network physician was not available for consultation.
- h. In the case where CalOptima Health or a Health Network and the treating Provider cannot reach an agreement concerning the Member's care and the CalOptima Health or Health Network physician is not available for consultation, CalOptima Health or the Health Network shall give the treating Provider the opportunity to consult with a CalOptima Health or Health Network physician and the treating Provider may continue with care of the Member until a CalOptima Health or the Health Network physician is reached or one (1) of the following criteria is met:
 - i. CalOptima or the Health Network physician with privileges at the treating Provider's hospital assumes responsibility for the Member's care;
 - ii. CalOptima Health or the Health Network physician assumes responsibility for the Member's care through transfer;
 - iii. CalOptima Health or the Health Network and the treating Provider reach an agreement concerning the Member's care; or
 - iv. The Member is discharged.

2. Medically Necessary Non-Urgent Care Following Emergency Room Exam

- a. For a CalOptima Health Direct Member enrolled in the Medi-Cal program, CalOptima Health shall process a Prior Authorization request from a non-contracted Provider for Medically Necessary non-urgent care following an exam in the emergency room in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers.
 - b. For a Health Network Member enrolled in the Medi-Cal program, a Health Network shall approve or deny a Prior Authorization request for non-urgent care following an exam in the emergency room within thirty (30) minutes after receipt of such request from a non-contracted Provider on behalf of a Member, who has received Emergency Services. If the Health Network does not respond to such request within the required timeframe, Medically Necessary non-urgent care is deemed approved.
3. Health Network staff shall assist the hospital with timely Discharge Planning to facilitate transition to the most appropriate level of care following facility discharge in accordance with the Health Network's policy.

F. Second Medical Opinions

1. A Member or the Member's Authorized Representative has the right to request a second opinion.
2. For Medi-Cal, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's Customer Service Department 714-246-8500 or toll-free at 888-587-8088 TDD/TTY: 711), or the Member's Health Network.
3. For OneCare, a Member or the Member's Authorized Representative may request a second opinion from their Practitioner, or by contacting CalOptima Health's OneCare Customer Service Department (toll-free at 877-412-2734 TDD/TTY: 711), or the Member's Health Network.
4. CalOptima Health or a Health Network requires Prior Authorization for a second opinion by a Specialist Physician.
5. A Member may receive a second opinion from an in-network Provider at no cost. If an in-network Provider is not available, CalOptima Health or their Health Network shall make arrangements for the Member to obtain a second opinion from an out-of-network Provider at no cost.
6. A Member may receive a third opinion, at no cost to a Member, if there is a disparity between the initial and second opinion.

G. Out-of-Network Services

1. CalOptima Health or a Health Network shall provide Medically Necessary and Covered Services to a Member through an out-of-network Provider when CalOptima Health or the Health Network is unable to provide services within the network, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
2. CalOptima Health or a Health Network shall adequately and timely cover out-of-network services, for as long as CalOptima Health or the Health Network is unable to provide the

services within the network. CalOptima Health or the Health Network shall process out-of-network service requests, as specified in the Timeframes for Decisions and Notifications Tables.

3. All requests requiring Prior Authorization shall require the requestor to submit a fully completed Authorization Request Form to CalOptima Health or the Health Network, along with medical justification sufficient to make a determination and the physician signature. CalOptima Health or the Health Network, shall process the request, as specified in the Timeframes for Decisions and Notifications Tables.
4. CalOptima Health or a Health Network shall follow the Timeframes for Decisions and Notifications Tables for all requested services, whether in or out of the network.
5. CalOptima Health or a Health Network shall arrange for a Letter of Agreement (LOA) with an identified out-of-network Provider, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.
6. CalOptima Health or a Health Network shall provide continued access as follows:
 - a. For newly enrolled Medi-Cal beneficiaries, for up to twelve (12) months, to an out-of-network Provider with whom the Member has had an ongoing relationship if there are no quality-of-care issues with the Provider and the Provider accepts contracted or Medi-Cal rates in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.
 - b. For Members eligible with the California Children's Services (CCS) Program and transitioned into the WCM program, for up to twelve (12) months, to an out-of-network CCS-paneled Provider, specialized or customized durable medical equipment provider, currently prescribed medication, and public health nurse, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services, and GG.1330: Case Management – California Children's Services Program/Whole Child Model.

H. Denials, Deferrals, Dismissals, Terminations and Modifications of Prior Authorization Requests

1. In-Network Specialist Physician

- a. CalOptima Health or a Health Network may redirect specialty care Prior Authorization requests to an in-network Specialist Physician under the following conditions:
 - i. All modification, denial, dismissal, termination and notification requirements are followed pursuant to regulation requirements; and
 - ii. The in-network Specialist Physician is selected based on the following:
 - a) A demonstrated ability to provide the services requested;
 - b) Prolific experience providing the services requested;
 - c) Volume of the requested care previously provided;
 - d) An existing relationship with CalOptima Health or the Health Network, as applicable;
 - e) A proven ability to maintain adequate Member access;

- f) A proven ability to provide care coordination;
- g) No existing issues related to continuity of care or Tertiary service needs; and
- h) For Members eligible with the CCS Program and transitioned into the WCM program, a CCS-paneled provider qualified to treat the CCS-Eligible Condition of the CCS child or youth, in accordance with CCS Program rules and regulations.

2. Consultation with Board-Certified Specialist

- a. CalOptima Health or a Health Network may consult with a Board-Certified specialist if the Prior Authorization request is out of the scope of practice of the physician reviewer.
 - i. A CalOptima Health or Health Network Medical Director shall forward a request for review by a Board-Certified specialist to the Prior Authorization manager or Designee for appropriateness;
 - ii. For a CalOptima Health Member, the Prior Authorization manager or Designee shall forward the request to a contracted external review agency electronically for review; and
 - iii. Upon receipt of the recommendation of the external review agency, the CalOptima Health Medical Director or Health Network shall conduct the final review and determination.
- b. The UMC shall maintain a list of Board-Certified specialists and will be reviewed annually by the Quality Improvement Committee (QIC).

3. Tertiary Care

- a. CalOptima Health or a Health Network shall authorize Tertiary Care Services when a Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care.
- b. CalOptima Health or a Health Network shall only authorize Tertiary Care services under the following circumstances:
 - i. A Member requires testing or treatment that is otherwise not available at a non-Tertiary level of care;
 - ii. A Member requires interdisciplinary or simultaneous treatments with multiple specialty services as part of a complex, coordinated plan of care;
 - iii. A Member requires testing or treatment that is otherwise too high of a risk or otherwise not safe to perform at a non-Tertiary level of care;
 - iv. A Member or Provider requires a referral for experimental or investigational procedures not available in-network and may do so directly through CalOptima Health; and
 - v. There is no quality-of-care issues for the Provider.

4. Utilization Management (UM) Decision

- 1 a. CalOptima Health and its Health Networks shall ensure the following:
- 2
- 3 i. Requested health care services may be approved by UM staff who are not qualified
- 4 health care professionals only when:
- 5
- 6 a) The UM staff is under the supervision of an appropriately licensed health
- 7 professional;
- 8
- 9 b) There are explicit UM criteria; and
- 10
- 11 c) No clinical judgement is required.
- 12
- 13 ii. Requested health care services which require the use of clinical judgement shall be
- 14 approved by licensed health care professionals.
- 15
- 16 iii. Decisions to deny or to authorize an amount, duration, or scope less than the requested
- 17 health care services shall be made by a qualified medical director with a current and
- 18 unrestricted license to practice in California or other health care professional with
- 19 appropriate clinical expertise in treating the condition and disease, including knowledge
- 20 of Medicare and Medi-Cal coverage criteria.
- 21
- 22 a) Only a qualified, licensed physician or other qualified health care professional, as
- 23 appropriate, shall deny or authorize an amount, duration, or scope less than the
- 24 requested health care services based in whole or in part on Medical Necessity for
- 25 any non-behavioral healthcare services.
- 26
- 27 b) Only a qualified, licensed physician or appropriate behavioral healthcare
- 28 practitioner as appropriate shall review and issue denials for Behavioral Health
- 29 Care services for Medical Necessity or benefit coverage related to a Medi-Cal
- 30 Member's behavioral health benefits; and
- 31
- 32 c) Only a qualified, licensed physician or qualified, licensed clinical pharmacist shall
- 33 review and approve, defer, modify or deny prior authorizations for pharmaceutical
- 34 services.
- 35
- 36 d) Only qualified, licensed health care professionals supervise review decisions
- 37 requiring Prior Authorization, including service reductions, and a qualified,
- 38 licensed physician shall review all denials of a request for health care services
- 39 based in whole or in part on Medical Necessity.
- 40

41 5. Notification of UM Decision

42

- 43 a. CalOptima Health and its Health Networks shall notify the requesting Practitioner or
- 44 Provider and/or Member or Member's Authorized Representative, as appropriate, regarding
- 45 any decision to deny, approve, modify, or delay an authorization request in accordance with
- 46 CalOptima Health Policy GG.1507: Notification Requirements for Covered Services
- 47 Requiring Prior Authorization. In addition, for OneCare, CalOptima Health and its Health
- 48 Networks shall ensure compliance with the notification requirements set forth in CalOptima
- 49 Health Policy MA.6042: Integrated Organization Determinations.
- 50
- 51 b. If Medical Necessity criteria are not met, and review by a CalOptima Health or Health
- 52 Network qualified licensed physician does not find the Member requires the requested
- 53 inpatient level of care and Prior Authorization request is denied, delayed, modified, or
- 54 alternative treatment is recommended, CalOptima Health or a Health Network shall notify

the Member, the Member's Authorized Representative, and the Practitioner or Provider of the reason for the action.

- i. CalOptima Health or the Health Network must provide auxiliary aids and services to a family member, friend, or associate of a Member if required by the ADA, including if the individual is identified as the Members' Authorized Representative, or is someone with whom it is appropriate for CalOptima Health or the Health Network to communicate.
- ii. Communication needs must be accommodated for all qualified Members with disabilities, including Authorized Representatives, and be prepared to facilitate alternate format requests for Braille, audio format, large print (no less than 20-point Arial font), and acceptable electronic format, such as a data CD, as well as requests for other auxiliary aids and services that may be appropriate, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- c. For routine (non-urgent) authorization requests, if CalOptima Health or a Health Network does not take action by approving, denying, deferring, or modifying services, on a written request for Prior Authorization of Covered Services within the timeframe specified in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization, such request shall be deemed denied by default and a notification of denial for the requested service shall be sent to the Provider and Member in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

I. Availability of CalOptima Health UM Staff and Services

1. CalOptima Health's UM Department shall provide Members or potential Members access to information about the UM process, and the process for authorizing care, in the Medi-Cal Member Handbook, and OneCare Evidence of Coverage available in-print and on the CalOptima Health website at www.caloptima.org.
2. CalOptima Health's UM Department shall provide Practitioners with access to information about the UM process, and the process for authorizing care, in the CalOptima Health Provider Manual, available on the CalOptima Health website at www.caloptima.org.
3. UM staff shall be available for inbound calls including toll free and collect calls, regarding UM issues during CalOptima Health normal business hours, Monday – Friday, from 8 a.m. to 5 p.m., with the exception of holidays. All inbound calls will be received by CalOptima Health's Customer Service Department and routed to appropriate UM staff.
 - a. UM staff shall provide a toll-free number and accept collect calls regarding UM issues.
 - b. UM staff shall identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.
 - c. UM staff shall send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
 - d. UM staff shall be accessible to callers who have questions about the UM process.
 - e. UM qualified, licensed physicians shall be available to answer denial determination questions during normal business hours and after hours calls regarding UM issues. During business hours, calls shall be directed to the UM Department and transferred to the

appropriate UM physician. The after-hours answering service shall direct calls to the on-call physician.

- f. A UM physician shall respond to a treating Provider request within thirty (30) minutes for an emergency call and within one (1) business day for all other requests.
4. UM staff shall be available to receive inbound communication regarding UM issues after normal business hours through the on-call-service, facsimile, electronic, and telephone communications (e.g., sending e-mail messages or leaving voicemail messages). Communications received after normal business hours are returned on the next business day. Communications received after midnight on Monday-Friday are responded to on the same business day.
5. CalOptima Health or its Health Network shall utilize a telecommunications device for the deaf/telephone typewriter, or teletypewriter (TDD/TTY) services for deaf, hard of hearing or speech impaired, or comparable device or service available to assist Members, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic and Services (CalOptima Health is able to receive and send TDD/TYY messages and has a separate phone number for receiving TDD/TYY messages.).
6. CalOptima Health for its Health Network shall provide language assistance services free of charge to Members. CalOptima Health shall provide services in the requested language through bilingual staff or an interpreter, to assist Members with UM issues, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
7. CalOptima Health shall send a CalOptima Health Medi-Cal Member Handbook/Evidence of Coverage (EOC) booklet as part of the enrollment packet, as specified in CalOptima Health Policy DD.2005: Member-Informing Materials Requirements. The handbook will note the availability of UM staff in regard to UM issues and will include the Customer Service Department phone number and the TDD/TTY phone number.
8. Annually, CalOptima Health shall inform Medi-Cal Members of the availability of the CalOptima Health Member Handbook/Evidence of Coverage.
9. Annually, CalOptima Health shall send via U.S. Mail the OneCare Evidence of Coverage, for OneCare Members.
- J. Failure of a Health Network or CalOptima Health department to comply with CalOptima Health's authorization policies and procedures, as applicable, as well as relevant statutory, regulatory, and/or contractual requirements, shall lead to disciplinary action which may include, but not be limited to, education and training on CalOptima Health's authorization process and reports to the Utilization Management Committee (UMC), Delegation Oversight Committee (DOC), and/or the Compliance Committee.
1. Continued non-compliance may lead to the issuance of a Corrective Action Plan (CAP) and/or Sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

- A. Timeframes for Medi-Cal Service Decisions and Notifications
- B. Timeframes for OneCare Service Decisions and Notifications

V. REFERENCE(S)

- 1
2 A. California Welfare and Institutions Code, §§14103.6 and 14185(a)(1)
3 B. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
4 C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Dual Eligible
5 Special Needs Plans (D-SNPs)
6 D. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization
7 Authorization Payment Disputes
8 E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for
9 Medicare Advantage
10 F. CalOptima Health, Health Network Service Agreement
11 G. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification
12 H. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
13 I. CalOptima Health Policy DD.2005: Member-Informing Materials Requirements
14 J. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
15 K. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
16 L. CalOptima Health Policy GG.1118: Family Planning Services, Out-of-Network
17 M. CalOptima Health Policy GG.1113: Specialty Practitioner Responsibilities
18 N. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima
19 Health Services
20 O. CalOptima Health Policy GG.1330: Case Management – California Children’s Services
21 Program/Whole Child Model
22 P. CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and
23 CalOptima Health Community Network Providers
24 Q. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring
25 Prior Authorization
26 R. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
27 S. CalOptima Health Policy HH.2002: Sanctions
28 T. CalOptima Health Policy HH.2005: Corrective Action Plan
29 U. CalOptima Health Utilization Management Program
30 V. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal
31 Requirements, Notice and “Your Rights” Templates (Revised 08/31/2022)
32 W. Department of Health Care Services (DHCS) All- Plan Letter (APL) 22-010: Cancer Biomarker
33 Testing
34 X. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-009: Post Stabilization Care
35 Services
36 Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003: Abortion and Directly
37 Related Medical Services and Supplies (Supersedes APL 22-022)
38 Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's
39 Services Whole Child Model Program (Supersedes APL 23-034)
40 AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-019: Consent to Outpatient
41 Mental Health Treatment or Counseling
42 BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-016: Alternative Format
43 Selection For Members With Visual Impairments (Supersedes APL 22-002)
44 CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed
45 Care Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)
46 DD. Family Code, Section 6924
47 EE. Health and Safety Code, Sections 1363.5 and 1367.01
48 FF. Medi-Cal Member Handbook
49 GG. Medicare Managed Care Manual “Benefits and Beneficiary Protections”, Section 20.3 Section
50 20.4 and Section 20.5.2
51 HH. National Committee for Quality Assurance (NCQA) HP Standards and Guidelines, MED 9
52 Element D, Factor 3
53 II. OneCare Evidence of Coverage
54 JJ. Title 28, California Code of Regulations (CCR), §1300.71.4

1 KK. Title 42, Code of Federal Regulations (CFR), §§ 422.112(a)(1)(iii), 422.113 (b)(2)(ii), (b)(3) and
2 (c), 422.138(a) and (b)(1-3), 422.562 (a)(4), 422.566 (a)(d), 422.590 (h), 422.629 (k)(3) and (4),
3 423.562(a)(5), 423.566 (a)(d), 423.590 (f), 438.114 (a), 438.404(a) and (c)(5), and 438.910(d)
4

5 **VI. REGULATORY AGENCY APPROVAL(S)**
6

Date	Regulatory Agency	Response
12/02/2009	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/17/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2018	Department of Health Care Services (DHCS)	Approved as Submitted
04/19/2021	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
08/17/2022	Department of Health Care Services (DHCS)	File and Use
09/27/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
02/22/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/19/2023	Department of Health Care Services (DHCS)	File and Use
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/07/2024	Department of Health Care Services (DHCS)	File and Use
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
05/08/2025	Department of Health Care Services (DHCS)	Approved as Submitted
12/22/2025	Department of Health Care Services (DHCS)	File and Use

7 **VII. BOARD ACTION(S)**
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Date	Meeting
06/03/2021	Regular Meeting of the CalOptima Board of Directors
09/04/2025	Regular Meeting of the CalOptima Health Board of Directors

10 **VIII. REVISION HISTORY**
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Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/1998	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	05/01/1999	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	07/01/2000	GG.1508	Health Network Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	10/01/2003	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	06/01/2007	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	01/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2009	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2011	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	02/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2012	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	09/01/2013	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2014	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	04/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal
Revised	08/01/2015	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Correction	05/10/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	03/01/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	06/03/2021	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	08/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	09/01/2022	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare OneCare Connect
Revised	01/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	08/01/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	12/31/2023	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	02/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	05/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	11/01/2024	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	04/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	06/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	07/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	12/01/2025	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	02/01/2026	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	03/01/2026	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised	03/01/2026	GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare
Revised		GG.1508	Authorization and Processing of Referrals	Medi-Cal OneCare

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For 20261001 BOD Review Only

IX. GLOSSARY

Term	Definition
Authorized Representative	For purposes of this policy, an individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423 (Subpart M), Part 422 (Subpart M), or Part 438 (Subpart F), as applicable, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the appeals process.
Authorization Request Form (ARF)	CalOptima Health's form to request authorization for Covered Services
Autism Spectrum Disorder (ASD)	A developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome.
Behavioral Health Care	Evaluation and treatment of psychological and substance abuse disorders. Specialty mental health services may include, but are not limited to, medication support services, day treatment intensive services, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facilities services.
Biomarker Test	A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment. Biomarkers, also called tumor markers, are substances found in higher-than-normal levels in the cancer itself, or in blood, urine, or tissues of some individuals with cancer. Biomarkers can determine the likelihood some types of cancer will spread. They can also help doctors choose the best treatment. For some cancers, certain tumor markers may be more helpful for staging than treatment planning.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
CalOptima Health Direct	A direct health care program operated by that includes both COHD-Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.

Term	Definition
Comprehensive Diagnostic Evaluation	A developmental screening that can be used to determine a diagnosis of autism spectrum disorder. It may also be able to identify other member needs if a diagnosis of ASD is not found.
Concurrent Review	A review of Medical Necessity of an authorization request for the Member's treatment regimen that is already in place while the Member is currently in an acute or post-acute setting, or in an ongoing course of care in an outpatient or community setting.
Continuity of Care	<u>Medi-Cal</u>: Services provided to a Member rendered by an Out-of-Network Provider with whom the Member has a pre-existing provider relationship. <u>OneCare</u>: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; and 5. Appropriate discharge planning; and Timely placement at different levels of care including hospital, skilled nursing, and home health care.
Covered Services	<u>Medi-Cal</u>: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as

Term	Definition
	specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.

Term	Definition
Discharge Planning	Planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services, and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.
Emergency Medical Condition	<u>Medi-Cal</u>: A medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: 1. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. Serious impairment to bodily function; and/or 3. Serious dysfunction of any bodily organ or part. <u>OneCare</u>: A medical condition that is manifested by acute symptoms of sufficient severity including severe pain such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. Placing the health of the Member (or, if the Member is a pregnant woman, the health of the Member and her unborn child) in serious jeopardy; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.
Emergency Services	<u>Medi-Cal</u>: Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. <u>OneCare</u>: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Initial Emergency Encounter	A Member's presentation to the emergency department for outpatient Emergency Services or the Member's inpatient emergency admission, whichever occurs first.
Medically Necessary or Medical Necessity	<u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic

Term	Definition
	Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dl(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	An individual enrolled in a CalOptima Health program.
Minor Consent Services	Those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations: 1. Sexual assault, including rape; 2. Drug or alcohol abuse for minors 12 years of age or older; 3. Pregnancy; 4. Family planning; 5. Sexually transmitted diseases (STDs) in minors 12 years of age or older; 6. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and 7. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code section 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or Child abuse.
Non-Contracted Provider	<u>Medi-Cal</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member. <u>OneCare</u>: A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Non-Specialty Mental Health Services (NSMHS)	Mild-to-moderate mental health coverage requirements of CalOptima for Medi-Cal Members that are delivered via managed care and include the following: 1. Mental health evaluation and treatment, including individual, group and family psychotherapy 2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition

Term	Definition
	3. Outpatient services for purposes of monitoring drug therapy 4. Psychiatric consultation 5. Outpatient laboratory, drugs, supplies and supplements
Organization Determination	Any decision made by an entity regarding receipt of, or payment for, a managed care item or service, the amount that the entity requires a member to pay for an item or service, or a limit on the quantity of items or service.
Out-of-Area	Outside of the Service Area
Out-of-Network	<u>Health Network</u>: Outside of the selected Health Network's participating provider network within the Service Area <u>Provider [CalOptima Health]</u>: A Provider that does not participate in CalOptima Health's Network.
Post-Stabilization Care Services	Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, in accordance with 42 CFR section 31.438.114 and 28 CCR section 1300.71.4 to improve or resolve the Member's condition.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prior Authorization	<u>Medi-Cal</u>: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services <u>OneCare</u>: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Professional Person	A person authorized to provide services under Family Code § 6924, including registered psychologists, psychology trainees, associate clinical social workers, social work interns, and psychiatrists.
Provider	<u>Medi-Cal</u>: 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. <u>OneCare</u>: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Prudent Layperson	A person who possesses an average knowledge of health and medicine, and the standard establishes the criteria that insurance coverage is based not on ultimate diagnosis, but on whether a prudent person might anticipate serious impairment to his or her health in an emergency situation.

Term	Definition
Qualified Licensed Physician	For purposes of this policy, if CalOptima Health or a Health Network expects to issue a partially or fully adverse medical necessity decision based on the initial review of the request, the request shall be reviewed by a qualified licensed physician with a current and unrestricted license to practice in California or other appropriate health professional with expertise in the field of medicine or health care that is appropriate for the services at issue, including knowledge of Medicare and Medi-Cal coverage criteria, before issuing the Coverage Decision Letter (OD) or Notice of Action (NOA).
Referral	The process of a Provider directing a Member to another Provider for care and /or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Retrospective Review	A form of medical records review that is conducted after the Member's discharge to track appropriateness of care and consumption of resources.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.
Specialist Physician	A physician who has obtained additional education/training in a focused clinical area and does not function as a PCP.
Tertiary Care	Specialized consultative care provided by specialists working in a center with personnel and facilities experienced in handling complex, uncommon or highly complicated diagnostics and treatments, such as organ transplants. Tertiary Care is provided upon Referral from primary or secondary medical personnel and is a level of care that is not available in a community setting.
Urgent Authorization Request	An authorization request required to be addressed within seventy-two (72) hours, as a normal timeframe for authorization will be detrimental to a Member's life or health, and jeopardizes the Member's ability to regain maximum function, or result in loss of life, limb, or other majorly body function.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

Attachment A

TIMFRAMES FOR MEDICAL DECISIONS AND NOTIFICATIONS

		Notification Timeframes	
		Member Notices: postmark will be used to confirm required timeframes.	
Type of Request	Decision	Electronic/Written Notification of <u>Practitioner Approvals</u>	Electronic/Written Notification of <u>Adverse Determinations</u> to Practitioner and Member
Routine (Non-urgent) Pre-Service Prospective or outpatient service requests. All necessary information is received at time of initial request.	Approve, Modify, or Deny as expeditiously as the member's health condition requires not to exceed 7 calendar days from date of receipt of the request	<u>Practitioner: Electronic/Written</u> Within 24 hours of making the decision not to exceed 7 calendar days from date of receipt of the request.	<u>Practitioner: Electronic/Written</u> Within 24 hours of making the decision not to exceed 7 calendar days from date of receipt of the request. (includes weekends and holidays) <u>Member: Written</u> Within 2 business days of the decision not to exceed 7 calendar days from date of receipt of the request. (includes weekends and holidays)
Routine (Non-urgent) Pre-Service – Extension Needed - Member request - Provider request - If CalOptima Health or the Health Network justifies a need for additional clinical information and how the extension is in the member's interest.	Additional Clinical Information Required: The decision may be deferred, and the time limit extended up to 14 calendar days from original date of receipt of the request.	<u>Practitioner: Electronic/Written</u> Written notice of "Delay" must be sent within 24 hours of making the decision to delay, not to exceed 7 calendar days from receipt of request. <u>Member: Written</u> Written notice of "Delay" <u>must</u> be sent within 2 business days of making the decision to delay, not to exceed 7 calendar days from receipt of the request.	<u>Practitioner: Electronic/Written</u> Written notice of "Delay" must be sent within 24 hours of making the decision to delay, not to exceed 7 calendar days from date of receipt of initial request for services. <u>Member: Written</u> Written notice of "Delay" <u>must</u> be sent within 2 business days of making the decision to delay, not to exceed 7 calendar days from date of receipt of the initial request for services.

Attachment A

TIMFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

		Notification Timeframes	
		Member Notices: postmark will be used to confirm required timeframes.	
Type of Request	Decision	Electronic/Written Notification of <u>Practitioner Approvals</u>	Electronic/Written Notification of <u>Adverse Determinations</u> to Practitioner and Member
	<u>Additional information received:</u> If requested information is received, decision must be made within 2 calendar days of receipt of information, not to exceed 14 calendar days from the date of receipt of the request for service. <u>Additional information incomplete or not received</u> If the provider does not comply with the request for additional information the decision must be made no later than 14 calendar days from the date of receipt of the initial request with the information that is available.	<u>Practitioner:</u> Within 24 hours of making the decision, not to exceed 14 calendar days from date of receipt of the request.	<u>Practitioner:</u> Within 24 hours of making the decision, not to exceed 14 calendar days from date of receipt of the request. <u>Member:</u> Within 2 business days of making the decision, not to exceed 14 calendar days from date of receipt of the request
Expedited Authorization (Pre-Service) Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. All necessary information is received at time of initial request.	Approve, Deny, or Modify as expeditiously as the member's health condition requires not to exceed 72 hours from receipt of the request.	<u>Practitioner: Electronic/Written</u> Within 24 hours of making the decision, not to exceed 72 hours from receipt of request.	<u>Practitioner: Electronic/Written</u> Within 24 hours of making the decision, not to exceed 72 hours from receipt of request. <u>Member: Written</u> Within 2 business days of making the decision, not to exceed 72 hours of receipt of the request.

Attachment A

TIMFRAMES FOR MEDICAL DECISIONS AND NOTIFICATIONS

		Notification Timeframes	
		Member Notices: postmark will be used to confirm required timeframes.	
Type of Request	Decision	Electronic/Written Notification of <u>Practitioner Approvals</u>	Electronic/Written Notification of <u>Adverse Determinations</u> to Practitioner and Member
<u>Concurrent</u> (Inpatient) Facility or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Concurrent review of treatment regimen already in place. All necessary information is received at time of initial request.	Approve, Deny, or Modify as expeditiously as the member's health condition requires not to exceed 72 hours from receipt of the request.	<u>Facility: Electronic/Written</u> Within 24 hours of making the decision not to exceed 72 hours from date of receipt of the clinical information	<u>Facility: Electronic/Written</u> Within 24 hours of making the decision not to exceed 72 hours from receipt of request. <u>Member: Written</u> Within 2 business days of making the decision, not to exceed 72 hours of receipt of request
<u>Concurrent</u> (Inpatient) - <u>Extension Needed</u> Concurrent review of treatment regimen already in place - Additional clinical information required. - Require consultation by an Expert Reviewer. - If CalOptima Health or the Health Network justifies a need for additional clinical information and how the extension is in the member's best interest	<u>Additional Clinical Information Required:</u> The decision may be deferred, and the time limit extended an additional 14 calendar days from date of receipt of request when: - Member or facility requests the extension, or - CalOptima Health or the Health Network justifies a need for additional information and can demonstrate how the extension is in the member's best interest. - There is reasonable likelihood that receipt of such information would lead to approval of the request.	<u>Facility: Electronic/Written</u> Written notice of "Delay" <u>must</u> be sent to the facility within 24 hours of the making the decision to delay, not to exceed 72 hours from date of receipt of request <u>Member: Written</u> Written notice of "Delay" <u>must</u> be sent within 2 business days of making the decision to delay, not to exceed 72 hours from receipt of the initial request	<u>Facility: Electronic/Written</u> Written notice of "Delay" <u>must</u> be sent to the treating facility within 24 hours of the decision to delay, not to exceed 72 hours from date of receipt of request. <u>Member: Written</u> Written notice of "Delay" <u>must</u> be sent within 2 business days of making the decision to delay, not to exceed 72 hours from date of receipt of the initial request.

Attachment A

TIMFRAMES FOR MEDICAL DECISIONS AND NOTIFICATIONS

		Notification Timeframes	
		Member Notices: postmark will be used to confirm required timeframes.	
Type of Request	Decision	Electronic/Written Notification of <u>Practitioner Approvals</u>	Electronic/Written Notification of <u>Adverse Determinations</u> to Practitioner and Member
	Additional Information Received: If requested information is received, a decision must be made within 1 business day of receipt of additional information not to exceed 14 calendar days from date of receipt of request Additional Information Incomplete or Not Received: If the facility does not comply with the request for additional information, the decision must be made no later than 14 calendar days from date receipt of the initial request with the information that is available.	<u>Facility: Electronic/Written</u> Notification must be provided to the facility within 24 hours of making the decision not to exceed 14 calendar days from date of receipt of request.	<u>Facility: Electronic/Written</u> Notification must be provided to the facility within 24 hours of making the decision not to exceed 14 calendar days from date of receipt of request. <u>Member: Written</u> Within 2 business days of making the decision, not to exceed 14 calendar days of date of receipt of request.
Post Service/Retrospective Review	Within 30 calendar days from receipt of request	<u>Practitioner:</u> Within 24 hours of making the decision not to exceed 30 calendar days from date of receipt of the request.	<u>Practitioner:</u> Within 24 hours of making the decision not to exceed 30 calendar days from receipt of request. <u>Member: Written</u> Within 30 calendar days of receipt of request.

Attachment B

TIMFRAMES FOR ONECARE SERVICE DECISIONS AND NOTIFICATIONS

Type of Request	Decision Timeframe	Notification Timeframe
<u>Standard Integrated Organization Determinations</u> Prior Authorization/Prospective or outpatient service requests.	Approve Modify or Deny no later than 7 calendar days from date of receipt of the request. Additional Information Required: A Health Network may extend the timeframe for a standard organization determination by up to 14 calendar days if: • The member or provider requests the extension; or • The Health Network can show that ➢ The extension is in the member's best interest; and ➢ There is a need for additional information and there is a reasonable likelihood that receipt of such information would lead to an approval of the organization determination, if received. If the organization determination is extended, a decision must be made within 21 calendar days from date of receipt of the request.	<u>Practitioner:</u> Decision: Electronic or Written Within 24 hours of making the decision, not to exceed 7 calendar days (including weekends and holidays) of date of receipt of the request <u>Practitioner/Member: Written</u> Within 2 business days of the decision, not to exceed 7 calendar days (including weekends and holidays) of date of receipt of the request Additional Information Received: <u>Practitioner:</u> Decision: Electronic or Written Within 24 hours of making the decision, not to exceed 21 calendar days (including weekends and holidays) of date of receipt of the request <u>Practitioner/Member: Written</u> Within 2 business days of the decision, not to exceed 21 calendar days (including weekends and holidays) of date of receipt of the request
<u>Expedited Integrated Organization Determinations</u> Prior Authorization/Prospective or outpatient service requests.	Approve, Modify, or Deny as expeditiously as possible, but no later than 72 hours from receipt of the request. Must request the necessary information from the provider within 24 hours of receipt of the request. Additional Information Required: A Health Network may extend the timeframe for a expedited organization determination by up to 14 calendar days if: • The member or provider requests the extension; or • The Health Network can show that: ➢ The extension is in the member's best interest; and ➢ There is a need for additional information and there is a reasonable likelihood that receipt of such information would lead to an approval of the organization determination, if received. If the organization determination is extended, a decision must be made within 17 calendar days from date of receipt of the request.	<u>Practitioner: Electronic or Verbal Notification</u> Within 24 hours of making the decision, not to exceed 72 hours of receipt of the request <u>Member/Practitioner: Written or Verbal Notification</u> Within 24 hours of the determination, not to exceed 72 hours of receipt of the request. <u>Member/Practitioner:</u> When a successful verbal notification is given, it must be followed by a written notification within 3 calendar days of the successful verbal notification. * *Reference: NCQA UM 5 Timeliness of UM Decisions Element A Notification of Nonbehavioral Healthcare Decisions Additional Information Received: <u>Practitioner:</u> Decision: Electronic or Written

Revised: 2/11/26

Attachment B

TIMFRAMES FOR ONECARE SERVICE DECISIONS AND NOTIFICATIONS

		Within 24 hours of making the decision, not to exceed 17 calendar days (including weekends and holidays) of date of receipt of the request Practitioner/Member: Written Within 2 business days of the decision, not to exceed 17 calendar days (including weekends and holidays) of date of receipt of the request
<u>Expedited Authorization (Pre-Service)</u> If Expedited Criteria are not met	If the request is submitted as expedited but determined not to be expedited, then the standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. The 7-calendar day period begins the day the request was received for an expedited determination.	If the request is not deemed to be expedited, provide verbal notification to the member within 72 hours of the denial of expedited status followed by a written notice within 3 calendar days of the verbal notification. ▪ Use the Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that CalOptima Health or the Health Network will automatically transfer and process the request using the 7-calendar day timeframe for standard determinations. 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member or the members' ability to regain maximum function. 4) Provide instructions about the expedited grievance process and its time frames.

Attachment B

TIMFRAMES FOR ONECARE SERVICE DECISIONS AND NOTIFICATIONS

<u>Concurrent</u> (Inpatient) Facility or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. All necessary information is received at time of the initial request	Approve Modify, or Deny as expeditiously as the member's health condition requires not to exceed 72 hours receipt of the request Extension: May extend the time frame, by up to 14 calendar days from the admission notification, under the following conditions: Additional supporting clinical information is needed.	Facility: Electronic Within 24 hours of making the decision not to exceed 72 hours from date of request of the clinical information. Member: Written Within 2 business days of making the decision, not to exceed 72 hours of receipt of request.
<u>Concurrent</u> (Inpatient)- Extension Needed Concurrent review of inpatient treatment regimen already in place	Additional Clinical Information Required: The decision may be deferred, and the time limit extended an additional 14 calendar days from date of receipt of request when: - Member or facility requests the extension, or - CalOptima Health or the Health Network justifies a need for additional information and can demonstrate how the extension is in the member's best interest. Additional Information Received: If requested information is received, a decision must be made within 1 business day of receipt of additional information not to exceed 14 calendar days from date of receipt of request Additional Information Incomplete or Not Received: If the facility does not comply with the request for additional information, the decision must be made no later than 14 calendar days from date receipt of the initial request with the information that is available.	Facility: Electronic/Written Written notice of the Delay must be sent to the facility within 24 hours of the decision to delay, not to exceed 72 hours from date of receipt of the request. Member: Written Written notice of the Delay must be sent within 2 business days of making the decision to delay, not to exceed 72 hours from date of receipt of the initial request. Facility: Electronic/Written: Notification must be provided to the facility within 24 hours of making the decision not to exceed 14 calendar days from date of receipt of request. Member: Written Within 2 business days of making the decision, not to exceed 14 calendar days of date of receipt of request
<u>Post-Service / Retrospective Review</u> All necessary information received at time of request (decision and notification is required within 30 calendar days from date of receipt of the request)	Decision within 30 calendar days from date of receipt of the request	Practitioner: Written Within 30 calendar days of receipt of the request Member: Written Within 30 calendar days of date of receipt of request.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve Modifications to Long Term Services and Supports Policy GG.1503

Contacts

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

Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Action

Approve the modifications to CalOptima Health Policy GG.1503: CalOptima Health Hospice Coverage, Notification and Validation Requirements pursuant to the Department of Health Care Services guidance, effective October 1, 2026.

Background

The Department of Health Care Services (DHCS) provided clarification to CalOptima Health that effective July 1, 2026, managed care plans (MCP) may apply prior authorization (PA) and other utilization management (UM) controls to all four hospice levels of care, expanding beyond the previous limitation to general inpatient care. MCPs may begin using these UM tools before a revised hospice All Plan Letter (APL) is issued but must continue following all current contractual, regulatory, and statutory requirements until DHCS releases the updated APL. This authority stems from Assembly Bill 116 (2025-2026 Regular Session) which makes the statutory restriction on hospice PA inoperative effective July 1, 2026 (Repealed as of January 1, 2027).

Discussion

CalOptima Health has updated Policy GG.1503: CalOptima Health Hospice Coverage, Notification and Validation Requirements to incorporate new PA requirements and update operational procedures for hospice services to align with state law and appropriate UM.

Summary of changes:

- Beginning November 1, 2026, CalOptima Health will require PA for routine home care, continuous home care, respite care, and general inpatient care across all hospice providers.
- CalOptima Health now expressly restricts coverage to in-network providers, except when medically necessary. Out-of-network hospice providers will require a single-use Letter of Agreement and PA, consistent with Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
- Staff has removed language referencing Medi-Cal Fee-For-Service hospice authorization processes as CalOptima Health will follow federal utilization review standards regardless of provider network status.

- PA processing will adhere to Policy GG.1508: Authorization and Processing of Referrals. Providers may submit routine, urgent, or retrospective requests through the CalOptima Health Provider Portal with required medical documentation. Alternate submission options include mail or fax, using a fully completed Authorization Request Form and supporting clinical documentation.
- Staff has removed attachments as CalOptima Health will no longer use the CalOptima Health-specific hospice request form after November 1, 2026.
- The revised policy now references Assembly Bill 116, affirming CalOptima Health's authority to require PA for hospice services.
- Standard member appeals and grievance rights continue to apply to any PA denials, consistent with existing CalOptima Health policies.

Fiscal Impact

The recommended action to modify the policy, including additional PA requirements and restrictions to limit the majority of services to in-network providers, is expected to reduce hospice expenses by approximately 20% compared to the forecasted costs in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

CalOptima Health is incorporating PA requirements for hospice services to ensure that hospice services are clinically appropriate and meet core eligibility requirements, such as physician certification of a terminal condition with a life expectancy of six months or less, proper completion of the hospice notice of election form, and timely submission within five days. These controls also play an important role in preventing inappropriate use of the hospice benefit, including claims for members who never elected hospice, and support program integrity efforts by aligning services with federal and state rules. The updated policy will supersede the prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. [CalOptima Health Policy GG.1503: CalOptima Health Hospice Coverage, Notification and Validation Requirements](#)



Policy: GG.1503
Title: **CalOptima Health Hospice Coverage, Notification and Validation Requirements**
Department: Long Term Services and Supports~~Medical Management~~
Section: Not Applicable~~Long Term Services and Supports~~
CEO Approval: /s/
Effective Date: 06/01/2001
Revised Date:
Applicable to: ☐ Administrative
☐ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

To clarify CalOptima Health's hospice benefit coverage, Notification and Validation requirements. All Hospice Providers will require authorizations beginning November 1, 2026, for Routine Home Care, Continuous Home Care, Respite Care, and General Inpatient Care.

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.C of this policy. CalOptima Health and its Health Networks shall be responsible for the following, in accordance with Health Network-specific Division of Financial Responsibilities (DOFR):

1. The following Hospice Care services as determined by the Member's enrollment in a CalOptima Health program:

CalOptima Health Program	CalOptima Health Hospice Care Services Responsibility				
	Routine Home Hospice (Rev Code 651)	Continuous Home Care (Rev Code 652)	Respite Care (Rev Code 655)	General Inpatient Care (Rev Code 656)	SNF: Room and Board (Rev Code 658)
Medi-Cal	Yes	Yes	Yes	Yes	Yes
OneCare	No*	No*	No*	No*	Yes

CalOptima Health Program	CalOptima Health Hospice Care Services Responsibility				
	Routine Home Hospice (Rev Code 651)	Continuous Home Care (Rev Code 652)	Respite Care (Rev Code 655)	General Inpatient Care (Rev Code 656)	SNF: Room and Board (Rev Code 658)
CalOptima Health Direct Administrative (COD-A) Dual eligible Member	No*	No*	No*	No*	Yes
*Billed to Medicare Fee-For-Service/Original Medicare.					

2. Under section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, children receiving Medi-Cal who have elected to receive hospice services, or for whom hospice services have been elected, may continue to receive services to treat their terminal illness; and
3. Room and Board coverage for a Member residing in a Long-Term Care (LTC) facility through the Medi-Cal benefit and receiving Hospice Care services.

B. Medicare Hospice Benefit Eligibility Requirements:

1. Medicare Part A (Hospital Insurance) coverage;
2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease runs its normal course);
3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and
4. The Member or Authorized Representative signs a statement choosing Hospice Care instead of other Medicare-covered treatments for the Terminal Illness and related conditions.

C. Requirements for the initiation of outpatient Medi-Cal Hospice services include:

1. Medi-Cal is the Member's primary inpatient/hospital coverage;
2. The attending physician and/or the hospice medical director certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease is to run its normal course);
 - a. Guidance for determining terminal status provided by the Centers for Medicare & Medicaid Services (CMS) is not wholly restrictive and/or inclusive for CalOptima Health Members to receive hospice 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 judgement, as some Members may not meet these guidelines, yet still have a life expectancy of six (6) months or less.
3. The Member or Authorized Representative understands and accepts hospice care in lieu of curative care for the terminal illness;

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4. 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.
 5. 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 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
 6. CalOptima Health will not deny Hospice Care to Members certified as Terminally Ill .
- D. For Members with both Medicare and Medi-Cal coverage (dual eligibles), CalOptima Health will ensure that Medicare remains the primary payor for the Hospice Care services. CalOptima Health will cover the cost sharing for contracted services.
1. For dually eligible Skilled Nursing Facility (SNF) residents, in accordance with Medicare policy payment for room and board will be made directly to the Hospice Provider. Room and board charges are not covered under Medicare. Following payment from Medicare, the Hospice Provider then bills CalOptima Health for the co-payment amount. The total reimbursed cannot exceed the Medicare rate.
 2. For Medicare Members entitled to only Medicare Part B, hospice benefits will be billed directly to CalOptima Health. No Medicare denial will be required.
 3. CalOptima Health will not require authorization for the Hospice Provider to bill CalOptima Health for the room and board covered by Medi-Cal while the patient is receiving hospice services under Medicare. Furthermore, CalOptima Health will not require a copy of an Explanation of Benefits, Remittance Advice, or denial letter from Medicare to accompany room and board claim.
 - ~~4. Hospice Providers must submit the Department of Health Care Services (DHCS) election form to both DHCS and CalOptima Health for dual eligibles when a Member elects the Medicare hospice benefit.~~
 - ~~5.4~~ CalOptima Health will pay the room and board to the Hospice Provider according to the previously agreed upon rate and the Hospice Provider is responsible for paying the nursing facility. Eligibility for the Medi-Cal nursing home room and board payment continues to be determined by the nursing home and CalOptima Health. The nursing facility continues to be responsible for collecting the Share of Cost, if applicable.
 - ~~6.5~~ If hospice services, including room and board services, are covered by a recipient's Other Health Coverage (OHC) insurance, CalOptima Health or a Health Network- must ensure Hospice Providers bill the OHC prior to billing CalOptima Health. A copy of the Explanation, Remittance Advice, or denial letter must accompany each Medi-Cal claim for services.

1 E. CalOptima Health is required to provide hospice services upon Member election to start and receive
2 such care. A Member may elect to receive hospice care during one or more of the following periods:
3 (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of
4 subsequent 60-day periods. A benefit period starts the day the Member receives Hospice Care and
5 ends when the ninety (90)-day or sixty (60)-day period ends.
6

- 7 1. For the initial ninety (90)-day benefit period, the Hospice Provider must obtain written
8 certification statements from the medical director of the hospice, the physician designee (as
9 defined in 42 CFR 418.3), or the physician member of the hospice interdisciplinary group; as
10 well as the Member's attending physician (generally the Member's Primary Care Physician
11 and/or referring physician), if the Member has an attending physician.
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- 13 2. For subsequent benefit periods, the certification must be done by the medical director of the
14 hospice, the physician designee, or the physician member of the hospice interdisciplinary.
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16 F. Revocation of Hospice:

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- 18 1. A Member's voluntary election of hospice may be revoked or modified at any time during the
19 benefit period.
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- 21 2. To revoke the election of Hospice Care, the Member or Authorized Representative must file a
22 signed statement with the Hospice Provider revoking the individual election for the remainder of
23 that benefit period, including the effective date of the revocation.
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- 25 3. The Hospice Provider must submit the Member's signed hospice revocation statement to
26 CalOptima Health within five (5) calendar days.
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- 28 4. The revocation effective date may not be retroactive.
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- 30 5. At any time after revocation, or discharge by the hospice for cause, a Member may execute a
31 new election, if they meet hospice coverage eligibility requirements.
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- 33 6. If the Member is still eligible, and makes a hospice election, and is readmitted to the same or
34 different Hospice Provider, the 90/90/unlimited sixty (60)-day benefit periods of care restart.
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- 36 7. If the Member re-elects Hospice Care, the Hospice Provider must submit a new hospice election
37 form to CalOptima Health.
38
- 39 8. The Member or Authorized Representative may change the designation of a Hospice Provider
40 once in each benefit period from the original Hospice Provider with which the election was
41 made. This change of the designated Hospice Provider is not a revocation of the hospice benefit.
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43 G. Members who elect Hospice Care are entitled to curative treatment for conditions unrelated to their
44 Terminal Illness.
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46 H. Services for children with life-threatening conditions
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- 48 1. Under the Early and Period Screening, Diagnostic, and Treatment (EPSDT) benefit, children
49 receiving Hospice Care services for a Terminal Illness and life expectancy of six (6) months or
50 less may receive additional services than are available for adults. Children can, and often do,
51 live longer with a Terminal Illness because of aggressive treatment and their natural resilience.

2. 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.
 3. In addition, Hospice and palliative care is available for CCS eligible children in accordance with CCS Numbered Letter (NL) 12-1119: Palliative Care Options for CCS Eligible Children and NL 06-1011: Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care.
 4. CalOptima Health will work with CCS to facilitate Continuity of Care, including maintaining established patient provider relationships, to the greatest extent possible.
 5. CalOptima Health will coordinate care with CCS and/or other caregivers.
 6. CalOptima Health will adhere to program service coverage responsibilities, policies, and requirements, in accordance with CalOptima Health Policy GG.1330: Case Management – California Children’s Services Program/Whole-Child Model.
 7. Palliative care services provided in accordance with CalOptima Health Policy GG.1550: Palliative Care Services.
 8. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition.
- I. Four (4) levels of Hospice Care:
1. Routine Home Care;
 2. Continuous Home Care;
 3. Respite Care; and
 4. General Inpatient Care.
- J. Notification and Validation Requirements
1. A Member with Medicare A and B coverage living in the community (not in an LTC facility) shall be exempt from all Notification requirements related to coverage of professional services for hospice.
 2. For OneCare, and Medi-Cal primary Members, the Hospice Provider shall notify and coordinate with CalOptima Health or the Member’s assigned Health Network for covered healthcare services that are unrelated to the Terminal Illness.
 3. Medi-Cal primary Members may access Hospice Care within twenty-four (24) hours of Notification of Hospice request. Effective November 1, 2026, CalOptima Health ~~shall not will~~ require prior authorization for Hospice Care services under Routine Home Care, Continuous Home Care, ~~and Respite Care~~ levels of Hospice Care, and General Inpatient care (GIP). A Hospice Provider shall provide documentation to support these levels of care, including the appropriate DHCS election form (Medi-Cal Hospice Program Election Notice), to CalOptima

Health Long Term Services and Supports (LTSS) department 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.

Level of Care	Notification	Validation
Routine Home Care	<u>Authorization Required.</u> Notification Required – within five (5) calendar days of start of service.	Required for each certification period – two (2) ninety (90) calendar day periods, then unlimited 60 calendar day periods. Certification of Terminal Illness documentation must be presented prior to the expiration of the current certification period.
Continuous Home Care	<u>Authorization Required.</u> Notification Required – within five (5) calendar days of start of service.	Submit documentation to validate the Member has received a minimum of eight (8) hours of direct care within a twenty-four (24)-hour period.
Respite Care	<u>Authorization Required.</u> Notification Required – within five (5) calendar days of start of service.	Submit documentation to validate that Member received Respite Care. Retroactive approval will be granted on an intermittent, non-routine basis, up to five (5) consecutive days at a time.
General Inpatient Care	Authorization Required. Notification required within one (1) business day but no more than seven (7) calendar days of start of service.	Required – authorization will be granted in seven (7) day intervals upon Validation of medical needs justification
Service Intensity Add-on	Notification required within twenty-four (24) hours after Member's death	Submit documentation to validate the Member has received service provided by a Social Worker or Registered Nurse during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day up to seven (7) days
Special Physician Services	Notification required within thirty (30) calendar days of start of service	Submit documentation to validate the Member has received services provided by a physician specializing in services that meets the Member's specific needs, and the hospice employed physician is unable to meet the Member's needs, and limited to one (1) visit per day per Member

5. For Medi-Cal primary 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 services within the next business day or no later than seven (7) calendar days after the start of services. If a Hospice Provider ~~hospice provider~~ does not provide adequate clinical documentation or documents do not substantiate the need for General Inpatient Care, the CalOptima Health Medical Director

may reduce the Level of Care to Routine Home Care. Following such a decision, the Hospice Provider shall have the right to appeal the Level of Care decision, in accordance with CalOptima Health Policies GG.1510: Appeal Process, GG.1814: Appeal Process for Long-Term Care Facility, MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9015: Standard Integrated 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 Level of Care under the Medicare benefit.
7. CalOptima Health may require documentation of medical justification for Continuous Home Care and/or Respite Care following the provision of general inpatient and continuous care.
 - a. If the documentation does not support the Continuous Home Care or respite home care levels of care, or if the documentation is inadequate, reimbursement may be reduced to the rate for Routine Home Care.
 - b. The ~~H~~hospice Provider may submit an appeal for reconsideration of payment by including additional documentation of the Medical Necessity for the increased Level of Care.
8. Pursuant to the CalOptima Health Contract, hospice services are Covered Services and are not categorized as Long-Term Care (LTC) services regardless of the Member's expected or actual length of stay in a nursing facility while also receiving Hospice Care.
 - a. CalOptima Health cannot require authorization for room and board for Members receiving hospice services and residing in a SNF/Nursing Facility (NF) or intermediate care facility (ICF) as described in federal law.
 - b. A Member who is a resident of a SNF or ICF may elect Hospice Care. CalOptima Health will provide payment to the hospice for Hospice Care services (at the appropriate Level of Care).
 - c. The Hospice Provider must reimburse the SNF or ICF for the room and board at the rate negotiated between the ~~Hospice Provider hospice-provider~~ and the facility. Payment for the room and board must be equal to at least ninety-five (95) percent of the reimbursement the NF/SNF would have been reimbursed by Medi-Cal or CalOptima Health, less the Share of Cost. Payments by a Hospice Provider to a SNF/NF for room and board must not exceed what would have been received directly from Medi-Cal or CalOptima Health if the Member had not been enrolled in hospice.
 - d. LTC Members who elect the Medi-Cal hospice benefit are not disenrolled from CalOptima Health. The Hospice Provider will bill CalOptima Health using the six (6) listed revenue (and facility type) codes.
9. Notification for Routine Home Care during the last seven (7) days of life – Service Intensity Add-On (SIA)

- 1 a. If a Medi-Cal primary Member was determined to be in the last seven (7) days of life, the
2 Hospice Provider shall notify CalOptima Health within twenty-four (24) hours of Member's
3 expiration and request SIA when the following criteria are met:
4
5 i. The day was a Routine Home Care Level of Care day;
6
7 ii. The days occurred during the last seven (7) days of life and the Member expired;
8
9 iii. The service was provided in-person by a Social Worker or a Registered Nurse; and
10
11 iv. The SIA number of hours (in fifteen (15) minute increments) of service provided by a
12 Registered Nurse or Social Worker during the last seven (7) days of life met a minimum
13 of fifteen (15) minutes and a maximum of four (4) hours per day, up to seven (7) days,
14 not to exceed a combined maximum of 112 units.
15
16 10. If a CalOptima Health Member, regardless of CalOptima Health program enrollment, utilizes
17 Hospice Care services in a LTC facility, the Hospice Provider shall submit Notification for
18 facility services (room and board) to the CalOptima Health Long Term Services and Supports
19 (LTSS) Department.
20
21 a. The Hospice Provider shall submit a Notification for hospice services for a CalOptima
22 Health Medi-Cal Member within five (5) calendar days after the start of services for the
23 following Hospice Level of Care services utilizing the Hospice Validation / Notification
24 Form (HVNF) to include the dates of service along with documentation of services
25 provided:
26
27 i. Continuous Home Care;
28
29 ii. Routine Home Care;
30
31 iii. Respite Care; and
32
33 iv. Special Physician Services.
34
35 K. Member requests to change a Hospice Provider, the current Hospice Provider shall provide a
36 transferring Member with a transfer summary signed by the Member's hospice physician. The
37 transfer summary shall include, but not be limited to the following information:
38
39 1. Member's diagnosis;
40
41 2. Pain treatment, and management;
42
43 3. Medications;
44
45 4. Medical treatments;
46
47 5. Dietary requirement;
48
49 6. Known allergies;
50
51 7. Treatment plan; and

8. Previous hospice benefit period information.

- L. A Member who moves his or her legal residence outside of Orange County must disenroll from CalOptima Health. Hospice Providers shall provide transferring Members with a transfer summary which shall be signed by the physician. Upon enrollment in the new county, a “change in designated hospice” must be initiated. This may be done only once per election period.
- M. Members who qualify for and elect to receive hospice care services shall remain enrolled in a Managed Care Plan while receiving such services.
- N. CalOptima Health and its Health Networks, in accordance with the active DOFR, shall pay the standard per diem set by Medi-Cal to all Hospice Providers for Medi-Cal primary Members. For a Member who has Medicare and Medi-Cal residing in an LTC facility, the Hospice Provider shall bill Medicare for the hospice services and bill CalOptima Health for room and board.
- O. CalOptima Health and its Health Networks, in accordance with the active DOFR, shall pay two (2) different Routine Home Care rates for Medi-Cal primary Members, based upon the following:
1. Routine Home Care high rate: defined as day one (1) to sixty (60) of an episode; and
 2. Routine Home Care low rate: defined as day sixty-one (61) and beyond.
 3. For a Member who is discharged and readmitted to hospice within sixty (60) calendar days of that discharge, the Member’s hospice days will continue to follow the patient and count toward the Member days for the receiving hospice in the determination of whether the receiving Hospice Provider may be considered at the high or low Routine Home Care rate, upon hospice election.
 4. For a Member who has been discharged from Hospice Care for more than sixty (60) calendar days, a new election to Hospice will initiate a reset of the Member’s sixty (60) calendar day window and it is considered at the Routine Home Care high rate upon the new Hospice election.
- P. Special Physician Services for Medi-Cal primary Members
1. A Hospice Provider shall submit a Notification with medical justification including diagnoses related to the Member’s Terminal Illness. CalOptima Health shall review and make medical determination for requests for Special Physician Services for pain and symptom management based on medical justification. The Special Physician Services shall not be provided by the Member’s Hospice attending physician and requires:
 - a. Immediate need; and
 - b. The Hospice attending physician does not have the required special skills.
 2. Special Physician Services is limited to one (1) visit-per-day, per Member.
- Q. 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).

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- R. CalOptima Health or its Health Network, in accordance with the active DOFR, may provide ongoing care coordination to a OneCare, or Medi-Cal primary Member 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.
- S. The Member may still receive medical services not related to the Terminal Illness through Medicare Part A and B or a Medicare health plan.
- T. CalOptima Health shall not approve any claims requests submitted after one (1) year from the date of service.
- U. For exceptional circumstances, Hospice Providers that submit a claim after twelve (12) months from the month of service shall provide acceptable documentation justifying the reason for delay. Acceptable documentation may include:
1. Court decisions;
 2. Fair hearing decisions;
 3. County administrative errors in determining Member eligibility;
 4. Reversal of decisions on appealed Authorization Request Form (ARF);
 5. Medicare/OHC delays; or
 6. Other circumstances beyond the Hospice Provider's control (i.e., natural disasters).
- V. CalOptima Health shall ensure for any authorizations for which it is responsible, for Hospice Care services under the Medi-Cal benefit, are consistently applied to medical/surgical, mental health, and substance use disorder services.
- W. CalOptima Health will contract with Hospice Providers or establish a Letter of Agreement (LOA), as appropriate with out-of-network providers, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.
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 (CDHP); and
 - c. Has a National Provider Identification number.
 2. CalOptima Health ~~may~~shall restrict coverage to in-~~Network Providers~~network providers, unless Medically Necessary services are not available in-Network, consistent with contractual requirements for covered Medi-Cal benefits. Out-of-network non-contracted Hospice Providers hospice providers will be subject to a single use letter of agreement and prior authorization in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

- 1 X. CalOptima Health shall ensure Continuity of Care for Members receiving Hospice Care, in
2 accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members
3 Transitioning into CalOptima Health Services.
4
- 5 Y. CalOptima Health will instruct staff, subcontractors, downstream subcontractors, network providers,
6 other programs, and out-of-network providers of the importance of timely recognition of a
7 Member's eligibility for Hospice Care services and their election of Hospice Care services.
8
- 9 1. Once a Member elects hospice, CalOptima Health network providers and case management
10 staff will work closely with ~~Hospice Providers hospice providers~~ to facilitate the transfer of
11 services for the Member from those directed toward cure and/or prolongation of life, to those
12 directed toward palliation.
13
- 14 2. Ongoing care coordination will be provided to ensure that services necessary to diagnose, treat,
15 and follow-up on conditions unrelated to the Terminal Illness continue to be provided, or are
16 initiated as necessary, in accordance with CalOptima Health Policy GG.1508: Authorization
17 and Processing of Referrals.
18
- 19 Z. Services not provided by Hospice Provider:
20
- 21 1. Private pay room and board or residential care.
22
- 23 2. Acute in-patient hospitalization unrelated to the Terminal Illness.
24
- 25 3. Level A or Level B NF for unrelated issues.
26
- 27 4. Physician and/or consulting Physician Services not related to the Terminal Illness or Physician
28 Services where the physician is not an employee of hospice or providing services under an
29 arrangement with hospice.
30
- 31 5. Other necessary services for conditions unrelated to the Terminal Illness.
32
- 33 AA. CalOptima Health will remain proactive and vigilant regarding program integrity, especially those
34 that address Fraud, Waste and Abuse, as outlined in CalOptima Health's contract.
35
- 36 1. CalOptima Health will review documentation received from the Hospice Provider to determine
37 the qualification of the Member to receive hospice, and if appropriate, CalOptima Health will
38 request additional documentation for such a determination, to confirm the proper and
39 appropriate claim payments and service authorizations are made and not based on fraudulent
40 submissions.
41
- 42 BB. CalOptima Health will apply appropriate compliance review protocols and procedures regarding
43 claim processing and utilization management systems upon receipt of a hospice election form
44 and/or hospice claim to identify a Member as receiving hospice, including notifying Member's
45 PCP of the Member's election to hospice and adding other system indicators to flag Members
46 receiving hospice services.
47
- 48 1. CalOptima Health will initiate the DHCS indicator "900" to designate Members receiving
49 hospice in its electronic health record system.
50

1 CC. CalOptima Health is contractually obligated to report complete, accurate, reasonable, and timely
2 submission of Encounter Data, including data for the referring provider (attending physician),
3 rendering provider (Hospice Provider), and the starting day of service data fields to assist DHCS in
4 its program integrity activities.

5
6 DD. DHCS may inspect and audit CalOptima Health records, documents, and electronic systems to
7 ensure compliance with service delivery and/or claims payments.
8

9 **III. PROCEDURE**

10
11 A. CalOptima Health or its Health Networks, in accordance with the Health Network-specific DOFR,
12 shall be responsible for providing Hospice Care to a Medi-Cal primary Member if the following
13 criteria are validated:
14

- 15 1. The physician has executed a certification of Terminal Illness that complies with Title 42 Code
16 of Federal Regulations (CFR), Section 418.22.
- 17
18 2. The Notice of Election or Revocation Statement is signed by the Member or Member's
19 Authorized Representative. The following must be included on the form:
20
21 a. Identification of the Hospice Provider;
22
23 b. The Member's or the Member's Authorized Representative's acknowledgement that he or
24 she has full understanding that the Hospice Care services given as related to the Member's
25 Terminal Illness will be palliative, rather than curative in nature, unless the Member is a
26 child under twenty-one (21) years of age, and that certain specified Medi-Cal benefits are
27 waived by the election;
28
29 c. The effective date of election; and
30
31 d. The signature of the Member or the Member's Authorized Representative.
32
33 e. All Hospice Providers must complete the appropriate DHCS hospice election form and
34 addendum and submit them within five (5) calendar days to CalOptima Health LTSS
35 Department. The election form must include the following elements:
36
37 i. The identification of the hospice provider.
38
39 ii. The Member's or Authorized Representative's acknowledgement:
40
41 a) They have full understanding the hospice care given as it relates to the Member's
42 terminal illness will be palliative rather than curative in nature.
43
44 b) Certain specified Medi-Cal benefits are waived by the election.
45
46 iii. The effective date of the election.
47
48 iv. The signature of the Member or Authorized Representative.
49
50 v. All hospice providers must complete the appropriate DHCS hospice election form
51 addendum and submit them within five calendar days to CalOptima Health.

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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 services, hospice physician consultation for patients, dietary or nutritional counseling, bereavement, and grief and spiritual counseling.
- C. Medi-Cal program payments for hospice services are based upon the level of care provided so that ~~hospice~~ Hospice Providers may group services into the listed revenue codes as outlined in the Medi-Cal Provider Manual. The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice 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 Level of Care 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 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 (high rate) – first 60 days	0650
Continuous Home Care	0652
Inpatient Respite Care	0655
General Inpatient Care (no respite)/hospice general care	0655
Physician Services	0657
Routine home care (low rate) – day 61 and beyond	0659

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- E. Hospice day billed at the routine home care level in the first sixty (60) days of a hospice election is paid at the high routine home care rate. Hospice day billed at the routine home care level on day 61 or later of the hospice election is paid at the low routine home care rate. For a hospice Member that is discharged and readmitted to hospice services within sixty (60) days of the discharge, the hospice days will continue to follow the Member at the routine home care rates outlined above (i.e. the first 60 days paid at the high routine home care rate and day sixty-one (61) or later paid at the low routine home care rate). Also, if the hospice Member is discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the Member's sixty (60)-day window, paid at the routine home care high rate upon the new admission. Additionally, routine home care days that occur during the last seven days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.
- F. 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.

G. The Hospice Provider must use Revenue Code 0657 when billing for pain and symptom management related to a Member's terminal condition and provided by a physician employed by, or under arrangements ~~may-made~~ by, the Hospice Provider. CalOptima Health will reimburse Revenue Code 0657, which is limited to one-visit-per-day, per-Member.

H. Consulting/Special Physician Services Revenue Code 0657 may be billed only for Physician Services to manage symptoms that cannot be remedied by the Member's attending physician because of one of the following:

1. Immediate need; or
2. The attending physician does not have the required special skills.

~~I. The Medi-Cal Fee For Services (FFS) program does not permit prior authorization of hospice services, except for inpatient admissions, as outlined in state law, therefore, CalOptima Health will adhere to the same utilization review standards as required by federal law regardless of whether the services are rendered by an in-network or out of network provider~~

~~J.I.~~ Hospice Providers must submit the DHCS hospice election and addendum forms containing the necessary information and appropriate signatures to CalOptima Health.

~~K.J.~~ For Medi-Cal primary Members, CalOptima Health may approve Routine Home Care, Continuous Home Care, Respite Care or General Inpatient Care on a short-term basis for pain control or management of acute and severe problems. ~~A. To request authorization, . a~~ Hospice Provider must submit the following documents: to the CalOptima Health Utilization Management (UM) Department

~~1. CalOptima Health Hospice Notification/Validation Form (HNVF);~~

~~2.1.~~ A written prescription signed by the Member's attending physician;

~~3.2.~~ Member's signed election form;

~~3.~~ Certification of Terminal Illness;

~~4.~~ Clinical documentation that justifies General Inpatient Care Level of Care; and

~~4.5.~~ Initial written Plan of Care; at the time of reauthorization

- 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 attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care.

- c. The plan must be reviewed and updated at intervals specified in the Plan of Care by the attending physician, the medical director or physician designee, and the interdisciplinary group of the hospice.
- 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.

K. CalOptima Health will process authorization requests in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

1. A contracted Provider may submit a routine, urgent, or retrospective authorization request online via CalOptima Health Provider Portal. The contracted Provider must upload medical documentation to CalOptima Health Provider Portal to support the Medical Necessity of the requested services.

2. A Provider or Practitioner may submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department by:

a. Mail to: Attn Utilization Management Department
CalOptima Health PO Box 11033
Orange, CA 92856

b. Facsimile at 714-246-8579; or

c. Phone: 1-888-587-8088

~~5.1. Certification of Terminal Illness;~~

~~6.1. Clinical documentation that justifies General Inpatient Care Level of Care; and~~

~~7. Medication administration records or flow charts that document that services medically required for the General Inpatient Care.~~

L. Medi-Cal primary 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.

M. Hospice Notification and Validation for CalOptima Health Medi-Cal primary 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.
 - 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. DHCS and 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. In cases of Medi-Cal retroactive eligibility, the Notification must be submitted within one hundred twenty (120) calendar days after the State of California's eligibility determination.
2. 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 Level of Care pursuant to CalOptima Health Policy GG.1508: Authorization and Processing of Referrals. A Hospice Provider shall have the right to appeal the Level of Care decision, in accordance with CalOptima Health Policies GG.1510: Appeal Process, MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9015: Standard Integrated Appeals.
3. The Hospice Provider shall submit Notification of continued service to CalOptima Health, or its Health Network ~~using the Hospice Notification/Validation Form (HNVF)~~ prior to the expiration of the current election period and shall include:

- 1 a. Recertification of Terminal Illness: For the third benefit period re-certification, and every
2 re-certification thereafter, there must be a face-to-face encounter between the Member and
3 the hospice physician or nurse practitioner (NP) no more than thirty (30) days prior to the
4 certification date, to gather clinical findings to determine continued eligibility for hospice
5 care.
6
- 7 b. When a Hospice Provider newly admits (i.e. transfer/admission) a Member in the third or
8 later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to
9 the start of the benefit period. Under documented exceptional circumstances, a face-to-face
10 encounter within two (2) calendar days after admission will be considered timely.
11
- 12 4. Attestation requirements:
13
- 14 a. Face-to-face encounter with Member is required to determine eligibility and must be
15 performed by hospice physician or hospice nurse practitioner employed by the Hospice
16 Provider;
17
- 18 b. Physician signature and date must be separate and a distinct section of, or an addendum to,
19 the recertification form and must be clearly titled; and
20
- 21 c. Attestation performed by a nurse practitioner:
22
- 23 i. Must state clinical findings of visit was provided to the certifying physician; and
24
- 25 ii. Determine life expectancy of six (6) months or less, should the illness run its normal
26 course.
27
- 28 5. Timeframe requirements when a Member transfers from one Hospice Provider to another
29 Hospice Provider:
30
- 31 a. A receiving Hospice Provider may not know if a face-to-face recertification is necessary, as
32 such, the receiving Hospice Provider shall document in the Member's medical record all
33 efforts to obtain the previous hospice benefit period Certification of Terminal Illness, either
34 from the transferring Hospice Provider or from other sources; and
35
- 36 b. If the receiving Hospice Provider cannot determine the correct benefit period, the face-to-
37 face recertification clock starts from the time the receiving Hospice Provider completes the
38 intake process. This information must be maintained in the Member's medical record for
39 auditing purposes.
40
- 41 6. Timeframe for exceptional circumstance:
42
- 43 a. Face-to-face encounter is not obtained due to the Member is in the third or later benefit
44 period; or
45
- 46 b. Emergency weekend admission; or
47
- 48 c. Centers for Medicare & Medicaid Services (CMS) Data System and/or Provider Electronic
49 Health Record are not available; the Hospice Provider may be unaware that the Member is
50 in the third or later benefit period. In such documented cases, a face-to-face encounter that
51 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.

7. 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. For all CalOptima Health Members in an LTC facility electing Hospice Care services, the Hospice Provider shall submit ~~a completed Hospice Notification/Validation Form (HNVE)~~ and the following documents to CalOptima Health's LTSSUM Department:

a. Initial Plan of Care, including a physician signature and date;

b. Certification of Terminal Illness, including a physician signature and date; and

c. Hospice Election Form, including the election date and signature of the Member or the Member's Authorized Representative.

9. 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 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)

~~A. Notice of Election or Revocation Statement~~

~~B. Hospice Notification/Validation Form (HNVE)~~

Not Applicable

V. REFERENCE(S)

A. California Children's Services (CCS) Numbered Letter 06-1011: Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care

B. California Children's Services (CCS) Numbered Letter 12-1119: Palliative Care Options for CCS Eligible Children – Revised

C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal

D. Medicare Benefit Policy Manual, Chapter 9 section 20.3

E. California Assembly Bill 116, Chapter 21

~~E.F.~~ CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts

~~F.G.~~ CalOptima Health Policy ~~yes~~ GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services

G.H. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model

~~H.I.~~ CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
~~I.J.~~ CalOptima Health Policy GG.1510: Member Appeal Process
K. **CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services**
~~J.L.~~ CalOptima Health Policy GG.1550: Palliative Care Services
~~K.M.~~ CalOptima Health Policy GG.1814: Appeals Process for Long Term Care Facility
~~L.N.~~ CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
~~M.O.~~ CalOptima Health Policy MA.9015: Standard Integrated Appeals
~~N.P.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 25-008: Hospice Services and Medi-Cal Managed Care (Supersedes APL 13-014)
~~O.Q.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020: Palliative Care (Supersedes APL 17-015)
~~P.R.~~ Department of Health Care Services (DHCS) Hospice Care: General Billing Instructions
~~Q.S.~~ Department of Health Care Services (DHCS) Policy Letter (PL) 11-004: The Implementation of Section 2302 of The Affordable Care Act, Entitled "Concurrent Care For Children"
~~R.T.~~ Health and Safety Code, §§1339.31(b) and 1368.2
~~S.U.~~ Hospice Financial Responsibility Matrix
~~T.V.~~ Manual of Criteria (MOC) for Medi-Cal Authorization
~~U.W.~~ Medicare Claims Processing Manual, CR 9201, Chapter 11, Section 30.2.2
~~V.X.~~ Social Security Act, Sections 1905(o)(1), 1812(d)(1) and 2110(a)(23)
~~W.Y.~~ Title 22, California Code of Regulations, §§51349 and 51180 et seq.
~~X.Z.~~ Title 42, Code of Federal Regulations, §418 et seq.
~~AA.~~ Welfare and Institutions Code, §14133.85

~~Y.~~

VI. REGULATORY AGENCY APPROVAL(s)

Date	Regulatory Agency	Response
03/01/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/21/2020	Department of Health Care Services (DHCS)	Approved as Submitted
10/29/2025	Department of Health Care Services (DHCS)	Approved As Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
08/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2001	GG.1503	CalOptima Authorization Requirements for the Provision of Hospice Service	Medi-Cal
Revised	07/01/2007	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	10/01/2009	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	07/01/2013	GG.1503	CalOptima Coverage, Notification and Validation Requirements	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2014	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal
Revised	05/01/2016	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	08/06/2020	GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	06/01/2021	GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	07/01/2023	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	09/01/2024	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	09/01/2025	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
<u>Revised</u>		<u>GG. 1503</u>	<u>CalOptima Health Hospice Coverage, Notification and Validation Requirements</u>	<u>Medi-Cal</u> <u>OneCare</u>

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IX. IX. GLOSSARY

Term	Definition
Abuse	<u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.
Authorized Representative	<u>Medi-Cal</u>: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. <u>OneCare</u>: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
California Children's Services (CCS) Eligible Conditions	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
CalOptima Health Direct Administrative (COHD-A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members as described in CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
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.

Term	Definition
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 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	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 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;

Term	Definition
	9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Crisis	The period in which a Member requires continuous care for as much as twenty-four (24)-hours to achieve palliation or management of acute medical symptoms.
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)	<u>Medi-Cal</u>: 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. <u>OneCare</u>: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that:

Term	Definition
	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.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than twenty-one (21) years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
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).
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 Consortia (PHC), or a Shared Risk 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.
Hospice Care	The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a Hospice Provider or by others under arrangements made by a Hospice Provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home; 11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility. 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care, as defined in DHCS APL 18-020.

Term	Definition
Hospice Intensity Service (Add-On)	For purposes of this policy, Hospice services for routine home hospice level of care that can be billed during the last seven (7) days of life in fifteen (15) minute increments and not to exceed four (4) hours per day for a maximum of seven (7) days. 1. Code G0155: Services of clinical social worker in home health or hospice setting each fifteen (15) minutes. 2. Code G0299: Direct skill nursing services of a registered nurse (RN) in the home health or hospice setting, each fifteen (15) minutes. 3. Codes do not require prior authorization with a maximum of one hundred twelve (112) units allowed for the last seven (7) days of Member's life.
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 Title 22, California Code of Regulations, Section 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 Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health policies.
Medically Necessary or Medical Necessity	<u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services include Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	An individual enrolled in a CalOptima Health program.
Notification	For purposes of this policy, direct communication to LTSS staff for hospice services notification for routine home care, continuous and Respite Care within thirty (30) calendar days of start of services for CalOptima Health Members.

Term	Definition
Other Health Coverage (OHC)	Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements.
Palliative Care	As defined in California Health and Safety Code Section 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 Title 42, Code of Federal Regulations (CFR).
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.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before they become eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Skilled Nursing Facility (SNF)	<u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.
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

Term	Definition
	2. Hospice attending physician does not have the required special skills. 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.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Terminally Ill	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.
Validation	For purposes of this policy, documentation to support medical justification for services requested for CalOptima Health Members.
Waste	<u>Medi-Cal</u>: The overutilization or inappropriate utilization of services and misuse of resources. <u>OneCare</u>: 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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.



Policy: GG.1503
Title: **CalOptima Health Hospice Coverage, Notification and Validation Requirements**
Department: Long Term Services and Supports
Section: Not Applicable

CEO Approval: /s/

Effective Date: 06/01/2001

Revised Date:

Applicable to: ☐ Administrative
☐ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

To clarify CalOptima Health's hospice benefit coverage, Notification and Validation requirements. All Hospice Providers will require authorizations beginning November 1, 2026, for Routine Home Care, Continuous Home Care, Respite Care, and General Inpatient Care.

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.C of this policy. CalOptima Health and its Health Networks shall be responsible for the following, in accordance with Health Network-specific Division of Financial Responsibilities (DOFR):

1. The following Hospice Care services as determined by the Member's enrollment in a CalOptima Health program:

CalOptima Health Program	CalOptima Health Hospice Care Services Responsibility				
	Routine Home Hospice (Rev Code 651)	Continuous Home Care (Rev Code 652)	Respite Care (Rev Code 655)	General Inpatient Care (Rev Code 656)	SNF: Room and Board (Rev Code 658)
Medi-Cal	Yes	Yes	Yes	Yes	Yes
OneCare	No*	No*	No*	No*	Yes
CalOptima Health Direct Administrative (COD-A) Dual eligible Member	No*	No*	No*	No*	Yes

*Billed to Medicare Fee-For-Service/Original Medicare.

2. Under section 2302 of the Patient Protection and Affordable Care Act, effective March 23, 2010, children receiving Medi-Cal who have elected to receive hospice services, or for whom hospice services have been elected, may continue to receive services to treat their terminal illness; and
3. Room and Board coverage for a Member residing in a Long-Term Care (LTC) facility through the Medi-Cal benefit and receiving Hospice Care services.

B. Medicare Hospice Benefit Eligibility Requirements:

1. Medicare Part A (Hospital Insurance) coverage;
2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease runs its normal course);
3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and
4. The Member or Authorized Representative signs a statement choosing Hospice Care instead of other Medicare-covered treatments for the Terminal Illness and related conditions.

C. Requirements for the initiation of outpatient Medi-Cal Hospice services include:

1. Medi-Cal is the Member's primary inpatient/hospital coverage;
2. The attending physician and/or the hospice medical director certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease is to run its normal course);
 - a. Guidance for determining terminal status provided by the Centers for Medicare & Medicaid Services (CMS) is not wholly restrictive and/or inclusive for CalOptima Health Members to receive hospice 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 judgement, as some Members may not meet these guidelines, yet still have a life expectancy of six (6) months or less.
3. The Member or Authorized Representative understands and accepts hospice care in lieu of curative care for the terminal illness;
4. 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.
5. 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 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

6. CalOptima Health will not deny Hospice Care to Members certified as Terminally Ill .
- D. For Members with both Medicare and Medi-Cal coverage (dual eligibles), CalOptima Health will ensure that Medicare remains the primary payor for the Hospice Care services. CalOptima Health will cover the cost sharing for contracted services.
1. For dually eligible Skilled Nursing Facility (SNF) residents, in accordance with Medicare policy payment for room and board will be made directly to the Hospice Provider. Room and board charges are not covered under Medicare. Following payment from Medicare, the Hospice Provider then bills CalOptima Health for the co-payment amount. The total reimbursed cannot exceed the Medicare rate.
 2. For Medicare Members entitled to only Medicare Part B, hospice benefits will be billed directly to CalOptima Health. No Medicare denial will be required.
 3. CalOptima Health will not require authorization for the Hospice Provider to bill CalOptima Health for the room and board covered by Medi-Cal while the patient is receiving hospice services under Medicare. Furthermore, CalOptima Health will not require a copy of an Explanation of Benefits, Remittance Advice, or denial letter from Medicare to accompany room and board claim.
 4. CalOptima Health will pay the room and board to the Hospice Provider according to the previously agreed upon rate and the Hospice Provider is responsible for paying the nursing facility. Eligibility for the Medi-Cal nursing home room and board payment continues to be determined by the nursing home and CalOptima Health. The nursing facility continues to be responsible for collecting the Share of Cost, if applicable.
 5. If hospice services, including room and board services, are covered by a recipient's Other Health Coverage (OHC) insurance, CalOptima Health or a Health Network must ensure Hospice Providers bill the OHC prior to billing CalOptima Health. A copy of the Explanation, Remittance Advice, or denial letter must accompany each Medi-Cal claim for services.
- E. CalOptima Health is required to provide hospice services upon Member election to start and receive such care. A Member may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods. A benefit period starts the day the Member receives Hospice Care and ends when the ninety (90)-day or sixty (60)-day period ends.
1. For the initial ninety (90)-day benefit period, the Hospice Provider must obtain written certification statements from the medical director of the hospice, the physician designee (as defined in 42 CFR 418.3), or the physician member of the hospice interdisciplinary group; as well as the Member's attending physician (generally the Member's Primary Care Physician and/or referring physician), if the Member has an attending physician.
 2. For subsequent benefit periods, the certification must be done by the medical director of the hospice, the physician designee, or the physician member of the hospice interdisciplinary.
- F. 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 is still eligible, and makes a hospice election, and is readmitted to the same or different Hospice Provider, the 90/90/unlimited sixty (60)-day benefit periods of care restart.
 7. If the Member re-elects Hospice Care, the Hospice Provider must submit a new hospice election form to CalOptima Health.
 8. 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.
- G. Members who elect Hospice Care are entitled to curative treatment for conditions unrelated to their Terminal Illness.
- H. Services for children with life-threatening conditions
1. Under the Early and Period Screening, Diagnostic, and Treatment (EPSDT) benefit, children receiving Hospice Care services for a Terminal Illness and life expectancy of six (6) months or less may receive additional services than are available for adults. Children can, and often do, live longer with a Terminal Illness because of aggressive treatment and their natural resilience.
 2. 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.
 3. In addition, Hospice and palliative care is available for CCS eligible children in accordance with CCS Numbered Letter (NL) 12-1119: Palliative Care Options for CCS Eligible Children and NL 06-1011: Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care.
 4. CalOptima Health will work with CCS to facilitate Continuity of Care, including maintaining established patient provider relationships, to the greatest extent possible.
 5. CalOptima Health will coordinate care with CCS and/or other caregivers.
 6. CalOptima Health will adhere to program service coverage responsibilities, policies, and requirements, in accordance with CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model.

7. Palliative care services provided in accordance with CalOptima Health Policy GG.1550: Palliative Care Services.
8. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition.

I. Four (4) levels of Hospice Care:

1. Routine Home Care;
2. Continuous Home Care;
3. Respite Care; and
4. General Inpatient Care.

J. Notification and Validation Requirements

1. A Member with Medicare A and B coverage living in the community (not in an LTC facility) shall be exempt from all Notification requirements related to coverage of professional services for hospice.
2. For OneCare, and Medi-Cal primary Members, the Hospice Provider shall notify and coordinate with CalOptima Health or the Member's assigned Health Network for covered healthcare services that are unrelated to the Terminal Illness.
3. Medi-Cal primary Members may access Hospice Care within twenty-four (24) hours of Notification of Hospice request. Effective November 1, 2026, CalOptima Health will require prior authorization for Hospice Care services under Routine Home Care, Continuous Home Care, Respite Care, and General Inpatient care (GIP). A Hospice Provider shall provide documentation to support these levels of care, including the appropriate DHCS election form (Medi-Cal Hospice Program Election Notice), to CalOptima Health Long Term Services and Supports (LTSS) department 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.

Level of Care	Notification	Validation
Routine Home Care	Authorization Required. Notification Required – within five (5) calendar days of start of service.	Required for each certification period – two (2) ninety (90) calendar day periods, then unlimited 60 calendar day periods. Certification of Terminal Illness documentation must be presented prior to the expiration of the current certification period.
Continuous Home Care	Authorization Required. Notification Required – within five (5) calendar days of start of service.	Submit documentation to validate the Member has received a minimum of eight (8) hours of direct care within a twenty-four (24)-hour period.

Level of Care	Notification	Validation
Respite Care	Authorization Required. Notification Required – within five (5) calendar days of start of service.	Submit documentation to validate that Member received Respite Care. Retroactive approval will be granted on an intermittent, non-routine basis, up to five (5) consecutive days at a time.
General Inpatient Care	Authorization Required. Notification required within one (1) business day but no more than seven (7) calendar days of start of service.	Required – authorization will be granted in seven (7) day intervals upon Validation of medical needs justification
Service Intensity Add-on	Notification required within twenty-four (24) hours after Member's death	Submit documentation to validate the Member has received service provided by a Social Worker or Registered Nurse during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day up to seven (7) days
Special Physician Services	Notification required within thirty (30) calendar days of start of service	Submit documentation to validate the Member has received services provided by a physician specializing in services that meets the Member's specific needs, and the hospice employed physician is unable to meet the Member's needs, and limited to one (1) visit per day per Member

5. For Medi-Cal primary 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 services within the next business day or no later than seven (7) calendar days after the start of services. If a Hospice Provider does not provide adequate clinical documentation or documents do not substantiate the need for General Inpatient Care, the CalOptima Health Medical Director may reduce the Level of Care to Routine Home Care. Following such a decision, the Hospice Provider shall have the right to appeal the Level of Care decision, in accordance with CalOptima Health Policies GG.1510: Appeal Process, GG.1814: Appeal Process for Long-Term Care Facility, MA.9004: Expedited Pre-Service Integrated Appeal, and MA.9015: Standard Integrated 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 Level of Care under the Medicare benefit.
7. CalOptima Health may require documentation of medical justification for Continuous Home Care and/or Respite Care following the provision of general inpatient and continuous care.

- 1 a. If the documentation does not support the Continuous Home Care or respite home care
2 levels of care, or if the documentation is inadequate, reimbursement may be reduced to the
3 rate for Routine Home Care.
4
5 b. The Hospice Provider may submit an appeal for reconsideration of payment by including
6 additional documentation of the Medical Necessity for the increased Level of Care.
7
8 8. Pursuant to the CalOptima Health Contract, hospice services are Covered Services and are not
9 categorized as Long-Term Care (LTC) services regardless of the Member's expected or actual
10 length of stay in a nursing facility while also receiving Hospice Care.
11
12 a. CalOptima Health cannot require authorization for room and board for Members receiving
13 hospice services and residing in a SNF/Nursing Facility (NF) or intermediate care facility
14 (ICF) as described in federal law.
15
16 b. A Member who is a resident of a SNF or ICF may elect Hospice Care. CalOptima Health
17 will provide payment to the hospice for Hospice Care services (at the appropriate Level of
18 Care).
19
20 c. The Hospice Provider must reimburse the SNF or ICF for the room and board at the rate
21 negotiated between the Hospice Provider and the facility. Payment for the room and board
22 must be equal to at least ninety-five (95) percent of the reimbursement the NF/SNF would
23 have been reimbursed by Medi-Cal or CalOptima Health, less the Share of Cost. Payments
24 by a Hospice Provider to a SNF/NF for room and board must not exceed what would have
25 been received directly from Medi-Cal or CalOptima Health if the Member had not been
26 enrolled in hospice.
27
28 d. LTC Members who elect the Medi-Cal hospice benefit are not disenrolled from CalOptima
29 Health. The Hospice Provider will bill CalOptima Health using the six (6) listed revenue
30 (and facility type) codes.
31
32 9. Notification for Routine Home Care during the last seven (7) days of life – Service Intensity
33 Add-On (SIA)
34
35 a. If a Medi-Cal primary Member was determined to be in the last seven (7) days of life, the
36 Hospice Provider shall notify CalOptima Health within twenty-four (24) hours of Member's
37 expiration and request SIA when the following criteria are met:
38
39 i. The day was a Routine Home Care Level of Care day;
40
41 ii. The days occurred during the last seven (7) days of life and the Member expired;
42
43 iii. The service was provided in-person by a Social Worker or a Registered Nurse; and
44
45 iv. The SIA number of hours (in fifteen (15) minute increments) of service provided by a
46 Registered Nurse or Social Worker during the last seven (7) days of life met a minimum
47 of fifteen (15) minutes and a maximum of four (4) hours per day, up to seven (7) days,
48 not to exceed a combined maximum of 112 units.
49
50 10. If a CalOptima Health Member, regardless of CalOptima Health program enrollment, utilizes
51 Hospice Care services in a LTC facility, the Hospice Provider shall submit Notification for

1 facility services (room and board) to the CalOptima Health Long Term Services and Supports
2 (LTSS) Department.

3
4 a. The Hospice Provider shall submit a Notification for hospice services for a CalOptima
5 Health Medi-Cal Member within five (5) calendar days after the start of services for the
6 following Hospice Level of Care services utilizing the Hospice Validation / Notification
7 Form (HVNf) to include the dates of service along with documentation of services
8 provided:

9
10 i. Continuous Home Care;

11
12 ii. Routine Home Care;

13
14 iii. Respite Care; and

15
16 iv. Special Physician Services.

17
18 K. Member requests to change a Hospice Provider, the current Hospice Provider shall provide a
19 transferring Member with a transfer summary signed by the Member's hospice physician. The
20 transfer summary shall include, but not be limited to the following information:

21
22 1. Member's diagnosis;

23
24 2. Pain treatment, and management;

25
26 3. Medications;

27
28 4. Medical treatments;

29
30 5. Dietary requirement;

31
32 6. Known allergies;

33
34 7. Treatment plan; and

35
36 8. Previous hospice benefit period information.

37
38 L. A Member who moves his or her legal residence outside of Orange County must disenroll from
39 CalOptima Health. Hospice Providers shall provide transferring Members with a transfer summary
40 which shall be signed by the physician. Upon enrollment in the new county, a "change in designated
41 hospice" must be initiated. This may be done only once per election period.

42
43 M. Members who qualify for and elect to receive hospice care services shall remain enrolled in a
44 Managed Care Plan while receiving such services.

45
46 N. CalOptima Health and its Health Networks, in accordance with the active DOFR, shall pay the
47 standard per diem set by Medi-Cal to all Hospice Providers for Medi-Cal primary Members. For a
48 Member who has Medicare and Medi-Cal residing in an LTC facility, the Hospice Provider shall
49 bill Medicare for the hospice services and bill CalOptima Health for room and board.

50
51 O. CalOptima Health and its Health Networks, in accordance with the active DOFR, shall pay two (2)
52 different Routine Home Care rates for Medi-Cal primary Members, based upon the following:

1. Routine Home Care high rate: defined as day one (1) to sixty (60) of an episode; and
2. Routine Home Care low rate: defined as day sixty-one (61) and beyond.
3. For a Member who is discharged and readmitted to hospice within sixty (60) calendar days of that discharge, the Member's hospice days will continue to follow the patient and count toward the Member days for the receiving hospice in the determination of whether the receiving Hospice Provider may be considered at the high or low Routine Home Care rate, upon hospice election.
4. For a Member who has been discharged from Hospice Care for more than sixty (60) calendar days, a new election to Hospice will initiate a reset of the Member's sixty (60) calendar day window and it is considered at the Routine Home Care high rate upon the new Hospice election.

P. Special Physician Services for Medi-Cal primary Members

1. A Hospice Provider shall submit a Notification with medical justification including diagnoses related to the Member's Terminal Illness. CalOptima Health shall review and make medical determination for requests for Special Physician Services for pain and symptom management based on medical justification. The Special Physician Services shall not be provided by the Member's Hospice attending physician and requires:
 - a. Immediate need; and
 - b. The Hospice attending physician does not have the required special skills.
2. Special Physician Services is limited to one (1) visit-per-day, per Member.

Q. 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).

R. CalOptima Health or its Health Network, in accordance with the active DOFR, may provide ongoing care coordination to a OneCare, or Medi-Cal primary Member 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.

S. The Member may still receive medical services not related to the Terminal Illness through Medicare Part A and B or a Medicare health plan.

T. CalOptima Health shall not approve any claims requests submitted after one (1) year from the date of service.

U. For exceptional circumstances, Hospice Providers that submit a claim after twelve (12) months from the month of service shall provide acceptable documentation justifying the reason for delay. Acceptable documentation may include:

1. Court decisions;
2. Fair hearing decisions;

3. County administrative errors in determining Member eligibility;
 4. Reversal of decisions on appealed Authorization Request Form (ARF);
 5. Medicare/OHC delays; or
 6. Other circumstances beyond the Hospice Provider's control (i.e., natural disasters).
- V. CalOptima Health shall ensure for any authorizations for which it is responsible, for Hospice Care services under the Medi-Cal benefit, are consistently applied to medical/surgical, mental health, and substance use disorder services.
- W. CalOptima Health will contract with Hospice Providers or establish a Letter of Agreement (LOA), as appropriate with out-of-network providers, in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.
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 (CDHP); 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, consistent with contractual requirements for covered Medi-Cal benefits. Out-of-network non-contracted Hospice Providers will be subject to a single use letter of agreement and prior authorization in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
- X. CalOptima Health shall ensure Continuity of Care for Members receiving Hospice Care, in accordance with CalOptima Health Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.
- Y. 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, 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 GG.1508: Authorization and Processing of Referrals.
- Z. 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 NF 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.
- AA. 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.
- BB. 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 services.
1. CalOptima Health will initiate the DHCS indicator "900" to designate Members receiving hospice in its electronic health record system.
- CC. CalOptima Health is contractually obligated to report complete, accurate, reasonable, and timely submission of Encounter Data, including data for the referring provider (attending physician), rendering provider (Hospice Provider), and the starting day of service data fields to assist DHCS in its program integrity activities.
- DD. DHCS may inspect and audit CalOptima Health records, documents, and electronic systems to ensure compliance with service delivery and/or claims payments.

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 Medi-Cal primary Member if the following criteria are validated:
1. The physician has executed a certification of Terminal Illness that complies with Title 42 Code of Federal Regulations (CFR), Section 418.22.
 2. The Notice of Election or Revocation Statement 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 Medi-Cal benefits are waived by the election;
- c. The effective date of election; and
- d. The signature of the Member or the Member's Authorized Representative.
- e. All Hospice Providers must complete the appropriate DHCS hospice election form and addendum and submit them within five (5) calendar days to CalOptima Health LTSS Department. The election form must include the following elements:
 - i. The identification of the hospice provider.
 - ii. The Member's or Authorized Representative's acknowledgement:
 - a) They have full understanding the hospice care given as it relates to the Member's terminal illness will be palliative rather than curative in nature.
 - b) Certain specified Medi-Cal benefits are waived by the election.
 - iii. The effective date of the election.
 - iv. The signature of the Member or Authorized Representative.
 - v. All hospice providers must complete the appropriate DHCS hospice election form addendum and submit them within five calendar days to CalOptima Health.
- 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 services, hospice physician consultation for patients, dietary or nutritional counseling, bereavement, and grief and spiritual counseling.
- C. Medi-Cal program payments for hospice services are based upon the level of care provided so that Hospice Providers may group services into the listed revenue codes as outlined in the Medi-Cal Provider Manual. The Medicaid hospice rates for hospices' four levels of care are calculated based on the annual hospice 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 Level of Care 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 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 (high rate) – first 60 days	0650

Level of Care	Revenue Code
Continuous Home Care	0652
Inpatient Respite Care	0655
General Inpatient Care (no respite)/hospice general care	0655
Physician Services	0657
Routine home care (low rate) – day 61 and beyond	0659

- E. Hospice day billed at the routine home care level in the first sixty (60) days of a hospice election is paid at the high routine home care rate. Hospice day billed at the routine home care level on day 61 or later of the hospice election is paid at the low routine home care rate. For a hospice Member that is discharged and readmitted to hospice services within sixty (60) days of the discharge, the hospice days will continue to follow the Member at the routine home care rates outlined above (i.e. the first 60 days paid at the high routine home care rate and day sixty-one (61) or later paid at the low routine home care rate). Also, if the hospice Member is discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the Member's sixty (60)-day window, paid at the routine home care high rate upon the new admission. Additionally, routine home care days that occur during the last seven days of a hospice election ending with a patient discharged due to death are eligible for a service intensity add-on payment.
- F. 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.
- G. The Hospice Provider must use Revenue Code 0657 when billing for pain and symptom management related to a Member's terminal condition and provided by a physician employed by, or under arrangements made by, the Hospice Provider. CalOptima Health will reimburse Revenue Code 0657, which is limited to one-visit-per-day, per-Member.
- H. Consulting/Special Physician Services Revenue Code 0657 may be billed only for Physician Services to manage symptoms that cannot be remedied by the Member's attending physician because of one of the following:
1. Immediate need; or
 2. The attending physician does not have the required special skills.
- I. Hospice Providers must submit the DHCS hospice election and addendum forms containing the necessary information and appropriate signatures to CalOptima Health.
- J. For Medi-Cal primary Members, CalOptima Health may approve Routine Home Care, Continuous Home Care, Respite Care or General Inpatient Care. To request authorization, a Hospice Provider

must submit the following documents to the CalOptima Health Utilization Management (UM) Department

1. A written prescription signed by the Member's attending physician;
2. Member's signed election form;
3. Certification of Terminal Illness;
4. Clinical documentation that justifies General Inpatient Care Level of Care; and
5. Initial written Plan of Care at the time of reauthorization
 - 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 attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care.
 - c. The plan must be reviewed and updated at intervals specified in the Plan of Care by the attending physician, the medical director or physician designee, and the interdisciplinary group of the hospice.
 - 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.

K. CalOptima Health will process authorization requests in accordance with CalOptima Health Policy GG.1508: Authorization and Processing of Referrals.

1. A contracted Provider may submit a routine, urgent, or retrospective authorization request online via CalOptima Health Provider Portal. The contracted Provider must upload medical documentation to CalOptima Health Provider Portal to support the Medical Necessity of the requested services.
2. A Provider or Practitioner may submit a fully completed Authorization Request Form (ARF) including physician signature or written physician order, as well as current medical documentation supporting the need for the requested services to the CalOptima Health UM Department by:
 - a. Mail to: Attn Utilization Management Department
CalOptima Health PO Box 11033
Orange, CA 92856
 - b. Facsimile at 714-246-8579; or
 - c. Phone: 1-888-587-8088

L. Medi-Cal primary 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.

M. Hospice Notification and Validation for CalOptima Health Medi-Cal primary 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.
 - 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. DHCS and 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. In cases of Medi-Cal retroactive eligibility, the Notification must be submitted within one hundred twenty (120) calendar days after the State of California's eligibility determination.

- 1 2. If medical justification is not included or is inadequate for Continuous Home Care or General
2 Inpatient Care, a CalOptima Health Medical Director may modify the request to a lower Level
3 of Care pursuant to CalOptima Health Policy GG.1508: Authorization and Processing of
4 Referrals. A Hospice Provider shall have the right to appeal the Level of Care decision, in
5 accordance with CalOptima Health Policies GG.1510: Appeal Process, MA.9004: Expedited
6 Pre-Service Integrated Appeal, and MA.9015: Standard Integrated Appeals.
7
8 3. The Hospice Provider shall submit Notification of continued service to CalOptima Health, or its
9 Health Network prior to the expiration of the current election period and shall include:
10
11 a. Recertification of Terminal Illness: For the third benefit period re-certification, and every
12 re-certification thereafter, there must be a face-to-face encounter between the Member and
13 the hospice physician or nurse practitioner (NP) no more than thirty (30) days prior to the
14 certification date, to gather clinical findings to determine continued eligibility for hospice
15 care.
16
17 b. When a Hospice Provider newly admits (i.e. transfer/admission) a Member in the third or
18 later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to
19 the start of the benefit period. Under documented exceptional circumstances, a face-to-face
20 encounter within two (2) calendar days after admission will be considered timely.
21
22 4. Attestation requirements:
23
24 a. Face-to-face encounter with Member is required to determine eligibility and must be
25 performed by hospice physician or hospice nurse practitioner employed by the Hospice
26 Provider;
27
28 b. Physician signature and date must be separate and a distinct section of, or an addendum to,
29 the recertification form and must be clearly titled; and
30
31 c. Attestation performed by a nurse practitioner:
32
33 i. Must state clinical findings of visit was provided to the certifying physician; and
34
35 ii. Determine life expectancy of six (6) months or less, should the illness run its normal
36 course.
37
38 5. Timeframe requirements when a Member transfers from one Hospice Provider to another
39 Hospice Provider:
40
41 a. A receiving Hospice Provider may not know if a face-to-face recertification is necessary, as
42 such, the receiving Hospice Provider shall document in the Member's medical record all
43 efforts to obtain the previous hospice benefit period Certification of Terminal Illness, either
44 from the transferring Hospice Provider or from other sources; and
45
46 b. If the receiving Hospice Provider cannot determine the correct benefit period, the face-to-
47 face recertification clock starts from the time the receiving Hospice Provider completes the
48 intake process. This information must be maintained in the Member's medical record for
49 auditing purposes.
50
51 6. Timeframe for exceptional circumstance:
52

- 1 a. Face-to-face encounter is not obtained due to the Member is in the third or later benefit
2 period; or
3
4 b. Emergency weekend admission; or
5
6 c. Centers for Medicare & Medicaid Services (CMS) Data System and/or Provider Electronic
7 Health Record are not available; the Hospice Provider may be unaware that the Member is
8 in the third or later benefit period. In such documented cases, a face-to-face encounter that
9 occurs within two (2) calendar days after admission will be considered timely; or
10
11 d. Member expires within two (2) calendar days of admission without a face-to-face
12 encounter.
13
14 7. Medically Necessary Covered Services for conditions not related to a Member's Terminal
15 Illness that are provided to a Member receiving Hospice Care services shall require the same
16 prior authorizations as required for a Member not receiving Hospice Care services.
17
18 8. For all CalOptima Health Members in an LTC facility electing Hospice Care services, the
19 Hospice Provider shall submit the following documents to CalOptima Health's UM
20 Department:
21
22 a. Initial Plan of Care, including a physician signature and date;
23
24 b. Certification of Terminal Illness, including a physician signature and date; and
25
26 c. Hospice Election Form, including the election date and signature of the Member or the
27 Member's Authorized Representative.
28
29 9. Pharmacy
30
31 a. Medications related to the Member's Terminal Illness including, but not limited to:
32 hydration, pain, and nausea control, whether administered orally, by injection or
33 intravenous (IV), shall be included in the per diem hospice rate. These medications shall be
34 obtained through the hospice program and not the CalOptima Health pharmacy system.
35
36 b. Medications required for medical conditions not related to Member's Terminal Illness, such
37 as insulin for a diabetic, shall continue to be covered under the CalOptima Health pharmacy
38 program and shall be processed through the CalOptima Health pharmacy system, or by the
39 Health Network for those drugs covered under the Health Network's responsibility.
40

41 **IV. ATTACHMENT(S)**

42 Not Applicable
43
44

45 **V. REFERENCE(S)**

- 46
47 A. California Children's Services (CCS) Numbered Letter 06-1011: Authorization of Medically
48 Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care
49 B. California Children's Services (CCS) Numbered Letter 12-1119: Palliative Care Options for CCS
50 Eligible Children – Revised
51 C. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
52 D. Medicare Benefit Policy Manual, Chapter 9 section 20.3

- E. California Assembly Bill 116, Chapter 21
- F. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
- G. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
- H. CalOptima Health Policy GG.1330: Case Management – California Children’s Services Program/Whole-Child Model
- I. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
- J. CalOptima Health Policy GG.1510: Member Appeal Process
- K. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
- L. CalOptima Health Policy GG.1550: Palliative Care Services
- M. CalOptima Health Policy GG.1814: Appeals Process for Long Term Care Facility
- N. CalOptima Health Policy MA.9004: Expedited Pre-Service Integrated Appeal
- O. CalOptima Health Policy MA.9015: Standard Integrated Appeals
- P. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-008: Hospice Services and Medi-Cal Managed Care (Supersedes APL 13-014)
- Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020: Palliative Care (Supersedes APL 17-015)
- R. Department of Health Care Services (DHCS) Hospice Care: General Billing Instructions
- S. Department of Health Care Services (DHCS) Policy Letter (PL) 11-004: The Implementation of Section 2302 of The Affordable Care Act, Entitled "Concurrent Care For Children"
- T. Health and Safety Code, §§1339.31(b) and 1368.2
- U. Hospice Financial Responsibility Matrix
- V. Manual of Criteria (MOC) for Medi-Cal Authorization
- W. Medicare Claims Processing Manual, CR 9201, Chapter 11, Section 30.2.2
- X. Social Security Act, Sections 1905(o)(1), 1812(d)(1) and 2110(a)(23)
- Y. Title 22, California Code of Regulations, §§51349 and 51180 et seq.
- Z. Title 42, Code of Federal Regulations, §418 et seq.
- AA. Welfare and Institutions Code, §14133.85

VI. REGULATORY AGENCY APPROVAL(s)

Date	Regulatory Agency	Response
03/01/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/21/2020	Department of Health Care Services (DHCS)	Approved as Submitted
10/29/2025	Department of Health Care Services (DHCS)	Approved As Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
08/06/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2001	GG.1503	CalOptima Authorization Requirements for the Provision of Hospice Service	Medi-Cal
Revised	07/01/2007	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2009	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	07/01/2013	GG.1503	CalOptima Coverage, Notification and Validation Requirements	Medi-Cal
Revised	03/01/2014	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal
Revised	05/01/2016	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	08/06/2020	GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	06/01/2021	GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	07/01/2023	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	09/01/2024	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised	09/01/2025	GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare
Revised		GG. 1503	CalOptima Health Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Abuse	<u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.
Authorized Representative	<u>Medi-Cal</u>: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member. <u>OneCare</u>: Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
California Children's Services (CCS) Eligible Conditions	A medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
CalOptima Health Direct Administrative (COHD-A)	The managed Fee-For-Service health care program operated by CalOptima Health that provides services to Members as described in CalOptima Health Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
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.

Term	Definition
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 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	<u>Medi-Cal</u>: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 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;

Term	Definition
	9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract.
Crisis	The period in which a Member requires continuous care for as much as twenty-four (24)-hours to achieve palliation or management of acute medical symptoms.
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)	<u>Medi-Cal</u>: 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. <u>OneCare</u>: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that:

Term	Definition
	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.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than twenty-one (21) years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
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).
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 Consortia (PHC), or a Shared Risk 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.
Hospice Care	The provision of palliative and supportive items and services to a Terminally Ill Member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a Hospice Provider or by others under arrangements made by a Hospice Provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of Crisis and only as necessary to maintain the Terminally Ill Member at home; 11. Inpatient Respite Care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility. 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care, as defined in DHCS APL 18-020.

Term	Definition
Hospice Intensity Service (Add-On)	For purposes of this policy, Hospice services for routine home hospice level of care that can be billed during the last seven (7) days of life in fifteen (15) minute increments and not to exceed four (4) hours per day for a maximum of seven (7) days. - Code G0155: Services of clinical social worker in home health or hospice setting each fifteen (15) minutes. - Code G0299: Direct skill nursing services of a registered nurse (RN) in the home health or hospice setting, each fifteen (15) minutes. - Codes do not require prior authorization with a maximum of one hundred twelve (112) units allowed for the last seven (7) days of Member's life.
Hospice Provider	A public agency or private organization, or a subdivision thereof, or a facility which: - Is primarily engaged in providing the items and services described in Title 22, California Code of Regulations, Section 51180 to Terminally Ill Members; - Make such services available as needed on a 24-hour basis, and - Provides bereavement counseling for the immediate family and significant others.
Level of Care (LOC)	Criteria for determining admission to an LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima Health policies.
Medically Necessary or Medical Necessity	<u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services include Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	An individual enrolled in a CalOptima Health program.
Notification	For purposes of this policy, direct communication to LTSS staff for hospice services notification for routine home care, continuous and Respite Care within thirty (30) calendar days of start of services for CalOptima Health Members.

Term	Definition
Other Health Coverage (OHC)	Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements.
Palliative Care	As defined in California Health and Safety Code Section 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 Title 42, Code of Federal Regulations (CFR).
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.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before they become eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Skilled Nursing Facility (SNF)	<u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.
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

Term	Definition
	2. Hospice attending physician does not have the required special skills. 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.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Terminally Ill	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.
Validation	For purposes of this policy, documentation to support medical justification for services requested for CalOptima Health Members.
Waste	<u>Medi-Cal</u>: The overutilization or inappropriate utilization of services and misuse of resources. <u>OneCare</u>: 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.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Approve CalOptima Health Clinical Operations Policies Related to Covered California

Contacts

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

Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Action

Approve policies and procedures developed or updated to reflect clinical operational requirements for CalOptima Health's Covered California product, effective January 1, 2027:

1. CalOptima Health Policy GG.1667: Population Health Management Program;
2. CalOptima Health Policy GG.1201: Health Education Program;
3. CalOptima Health Policy GG.1708: Disease Management Program;
4. CalOptima Health Policy GG.1701: Maternity Services for Pregnant and Postpartum Members;
5. CalOptima Health Policy GG.1704: Breastfeeding Promotion;
6. CalOptima Health Policy GG.1707: Doula Services;
7. CalOptima Health Policy GG.1301: Comprehensive Care Management Process; and
8. CalOptima Health Policy CC.2100: CalOptima Health Covered Health Assessment and Case Management.

Background

Over the past two years, CalOptima Health has made significant progress preparing for entrance into the Covered California program. The CalOptima Health Board of Directors (Board) has taken several actions related to Covered California. On August 1, 2024, the CalOptima Health Board of Directors (Board) authorized the Chief Executive Officer (CEO) to convene a stakeholder steering committee composed of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on nine separate occasions. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California.

On August 6, 2026, the Board authorized CalOptima Health to execute the Qualified Health Plan contract with Covered California. On August 11, 2026, CalOptima Health received conditional

approval from the Department of Managed Health Care (DMHC) to expand the scope of its current Knox-Keene Act license to enable CalOptima Health to offer the Covered California product.

Discussion

On June 5, 2025, the Board approved several CalOptima Health policies related to Covered California regulatory requirements as part of the DMHC filing process. The process required the submission of at least 89 supporting exhibits demonstrating compliance with the requirements of the Knox-Keene Act. In addition to regulatory policies approved by DMHC, staff evaluated several operational policies and procedures determining that a policy change or update was needed to address operational changes to the Covered California product. While these policy updates do not require DMHC approval currently, they are required to support the implementation of CalOptima Health's Covered California product.

In the area of clinical operations, staff recommend approval of updates to eight (8) current policies and procedures related to population health management, diabetes prevention, disease management, health education, and maternal health. In addition, staff recommend approval of one (1) new policy and procedure related to health assessment and case management.

Policies & Procedures Summary – Population Health

<i>Policy</i>	<i>Summary of Change/Update</i>
CalOptima Health Policy GG.1667: Population Health Management Program	Added Covered California line of business to the policy and updated to align with July 2026 DHCS PHM Policy Guide and 2026 NCQA Standards.
CalOptima Health Policy GG.1201: Health Education Program	Updated policy to: 1. Clarify terminology throughout; 2. Remove reference to the Population Health Management Committee, and clarify that health education will instead report directly to the Quality Improvement and Health Equity Committee; and 3. Add the Covered California line of business to the policy.
CalOptima Health Policy GG.1708: Disease Management Program	New policy covering all lines of business, including Covered California.
CalOptima Health Policy GG.1701 Maternity Services for Pregnant and Postpartum Members	Added Covered California line of business to the policy.
CalOptima Health Policy GG.1704: Breastfeeding Promotion	Added Covered California line of business to the policy.
CalOptima Health Policy GG.1707: Doula Services	Added Covered California line of business to the policy.

Staff seek Board approval of the attached policies, effective January 1, 2027.

Policies & Procedures Summary – Case Management

<i>Policy</i>	<i>Summary of Change/Update</i>
CalOptima Health Policy GG.1301: Comprehensive Care Management Process	Updated policy to add Covered California line of business.
CalOptima Health Policy CC.2100: CalOptima Health Covered Health Assessment and Case Management	New policy related to health assessment and case management expectations for Covered California enrollees.

Staff seek Board approval of the attached policies, effective January 1, 2027.

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

Approval of updated and new policies and procedures related to clinical operations will support CalOptima Health's operational implementation of the Covered California program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment(s)

1. [CalOptima Health Policy GG.1667: Population Health Management Program](#)
2. [CalOptima Health Policy GG.1201: Health Education Program](#)
3. [CalOptima Health Policy GG.1708: Disease Management Program](#)
4. [CalOptima Health Policy GG.1701 Maternity Services for Pregnant and Postpartum Members](#)
5. [CalOptima Health Policy GG.1704: Breastfeeding Promotion](#)
6. [CalOptima Health Policy GG.1707: Doula Services](#)
7. [CalOptima Health Policy GG.1301: Comprehensive Care Management Process](#)
8. [CalOptima Health Policy CC.2100: CalOptima Health Covered Health Assessment and Case Management](#)



Policy: GG.1667
Title: ~~CalAIM~~ Population Health Management Program
Department: ~~Medical Case~~ Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 06/01/2023
Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy defines CalOptima Health's Population Health Management (PHM) Program and describes the process by which CalOptima Health, Health Networks, and Providers engage Members across delivery systems ~~and carved-out services~~ to identify health needs, stratify risk, and deliver coordinated interventions that improve health outcomes, reduce disparities, and promote Health Equity across the continuum of care.

II. POLICY

A. CalOptima Health shall establish and maintain a PHM Program in accordance with the Department of Health Care Services (DHCS) ~~All Plan Letter (APL) 22-024: Population and Department of Managed Health Management~~ (DMHC) requirements.

~~A.B.~~ The PHM Program shall align with the National Committee for Quality Assurance (NCQA) Health Plan and Health Outcomes Accreditation standards.

~~B.C.~~ The PHM Program ensures that all Members have access to a comprehensive set of services based on their individual needs and preferences across the continuum of care, which promotes improved outcomes, and Health Equity.

~~C. The PHM Program shall align with the National Committee for Quality Assurance (NCQA) Health Plan and Health Equity standards.~~

~~D. The PHM Program includes Basic Population Health Management (BPHM), Care Management, Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services (TCS).~~

~~E. The PHM Program will include four (4) domains that define the PHM Framework:~~

~~1. PHM Strategy and Population Needs Assessment (PNA);~~

~~2. Gathering Member Information;~~

1 ~~3.— Understanding Risk; and~~

2
3 ~~4.— Providing Services and Supports.~~

4
5 ~~F.— CalOptima Health will meet the requirements of the PHM Framework domains in accordance with~~
6 ~~Section III of this Policy.~~

7
8 ~~G.D.~~ The goals of the PHM Program are to:

- 9
10 1. Build trust and ~~meaningfully~~meaningful engagement with Members;
- 11
12 2. Provide interventions to support health and wellness for all Members;
- 13
14 3. Utilize data-driven Risk Stratification, ~~standardize~~standardized assessment processes and
- 15 predictive analytics to address gaps in care;
- 16
17 4. Provide Care Management services for Members with increased risk of poor health outcomes;

18
19 ~~5.— Robust TCS;~~

20
21 ~~6.5.~~ Identify and mitigate Social Drivers of Health (SDOH) to reduce disparities; and

22
23 ~~7.6.~~ Address upstream factors by linking Members to public health and social services.

24
25 ~~H.— DHCS will launch and make available a statewide PHM service, Medi-Cal Connect, that will~~
26 ~~provide a wide range of current Member information to support key PHM Program functions which~~
27 ~~include but are not limited to:~~

28
29 ~~1.— Data integration;~~

30
31 ~~2.— Risk Stratification Segmentation (RSS) tiering;~~

32
33 ~~3.— Screening and assessment;~~

34
35 ~~4.— Analytics and reporting; and~~

36
37 ~~5.— Potential medical, behavioral and social supports.~~

38 39 **III. PROCEDURE**

40
41 ~~A.— PHM Strategy~~

42 ~~A.~~ CalOptima Health shall develop an annual PHM Strategy that meets the following requirements:

- 43
44 1. The PHM Strategy is a comprehensive, accountable plan of action for addressing Member needs
- 45 and preferences.

46
47 ~~2.— CalOptima Health shall develop an annual~~The PHM Strategy ~~that:~~

48
49 ~~3.2.~~ Outlines~~outlines~~ the PHM Program; including the following areas of focus:

50
51 a. Keeping Mmembers healthy;

52
53 b. Managing Mmembers with emerging risk;

54

c. Patient safety or outcomes across settings; and

d. Managing multiple chronic illnesses.

The PHM

3. Prioritizes Strategy describes the following for each area of focus:

a. A measurable, timebound goal and population of focus;

b. Programs or services offered;

c. At least three activities that support practitioners, providers, or community-based organizations;

d. How Member programs are coordinated across settings, providers, and levels of care;

e. How Members and practitioners are informed of available PHM programs and services; and

f. Describes the organization's commitment and strategies to address identified disparities.

a. The PHM Strategy prioritizes strong ties to the community;

b. Incorporates cross-sector strategies to improve health in all neighborhoods and communities where Members reside, especially those with poor health outcomes;

4. Incorporates and incorporates strategies and interventions to that address findings from the Population Needs Assessment (PNA) and the Orange County Health Care Agency's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP); and

a. Include Incorporates cross-sector strategies for improving access to children's preventive improve health visits in the neighborhoods and developmental screenings, ensuring follow up and Care Coordination needs communities where Members reside, especially those with poor health outcomes;

a.b. Aligns with quality improvement efforts identified from screenings delivered by DHCS, DMHC, and the Centers for Medicare and Medicaid Services (CMS).

5. Annually, CalOptima Health will update the PHM Strategy shall align with the DHCS Comprehensive Quality Strategy (CQS) Clinical Focus Areas and Bold Goals.

a. Clinical Focus Areas—DHCS defines three (3) focus areas:

i. Children's preventive care;

ii. Maternity care and birth equity; and

iii. Behavioral health integration.

b. Bold Goals—DHCS has defined and identified the following bold goals for year 2025:

i. Close racial/ethnic disparities in well child visits and immunizations;

- ii. ~~Close maternity care disparity for Black and Native American persons by fifty percent (50%);~~
- iii. ~~Improve maternal and adolescent depression screening by fifty percent (50%);~~
- iv. ~~Improve follow up for mental health and substance use disorder by fifty percent (50%);~~
~~and~~
- v. ~~Ensure all health plans exceed the fiftieth (50th) percentile for all children's preventive care measures.~~

~~6.5. Annually CalOptima Health shall review, update, and submit the PHM Strategy to DHCS regulatory and/or accreditation entities as required.~~

~~7.6. The CalOptima Health Population Quality Improvement and Health Management Equity Committee (PHMCQIHEC) shall provide oversight and monitor the PHM Strategy on a quarterly basis, and report to the Board of Directors Quality Improvement and Health Equity Assurance Committee (QIHECQAC).~~

B. CalOptima Health shall develop an annual Population Needs Assessment (PNA) that meets the following requirements:

~~1. CalOptima Health shall conduct a PNA~~Is conducted in accordance with ~~regulatory entities, strategic priorities, CalOptima Health Board of Directors directives, and any other managed care program requirements, NCQA~~ to gather and evaluate population-level data related to the health of its Members, including:

~~a. Characteristics and needs;~~

~~b. Social Drivers of Health (SDOH);~~

~~1. Needs of Members, including:~~

~~a. Cultural and linguistic needs;~~

~~b. Health education needs;~~

~~c. Health disparities and inequities;~~

~~d. Root causes of barriers related to coverage, access, quality, health outcomes; and~~

~~e. SDOH needs.~~

~~2. The PNA must address the special needs of CalOptima Health populations, including:~~

~~a. Seniors and Persons with Disabilities (SPD);~~

~~b.c. Children~~children and adolescents;

~~c. Persons with disabilities;~~

~~d. Members with disabilities, Serious and Persistent Mental Illness (SPMI); SMI) or serious emotional disturbance;~~

e. Member of racial or ethnic groups

e.f. Members with Limited English Proficiency (LEP); and

f. Other Member subgroups from diverse cultural, racial, and ethnic backgrounds in the PNA findings.

g. At least two characteristics or needs for two other relevant subpopulations distinct from those listed above.

3. CalOptima Health will satisfy the following PNA requirements:

4.2. CalOptima Health will use reliable data sources to identify Member health needs and health disparities. This process will include analyzing data to identify the differences in health outcomes, quality of care, and utilization, as well as the underlying reasons for variations in the provision potential root causes of care to Members. Data sources will include: these disparities.

i. The most recently available Consumer Assessment of Healthcare Providers and Systems (CAHPS);

ii. CalOptima Health specific health disparities data identified via claims, encounters, and other sources of aggregate Member data;

iii. Orange County Health Care Agency and data collected through the CHA/CHIP process;

iv. Relevant data from Subcontractors and Downstream Subcontractors;

v. Healthcare Effectiveness Data and Information Set (HEDIS®);

vi. Managed Care Accountability Sets (MCAS); and

vii. Language assistance services utilization reports.

5.3. Based on PNA findings, CalOptima Health will review community resources for integration into PHM program offerings and update health education, cultural and linguistic the PHM Strategy, including programs, services, and quality improvement activities, and resources.

a. CalOptima Health shall have a process to obtain stakeholder feedback on PNA findings and/or improvement opportunities. Stakeholders may include stakeholders, including, but not be limited to, the Member Advisory Committee (MAC), in PNA activities and) in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.

b. CalOptima Health shall engage the AA.1219a Member Advisory Committee and Provider Advisory Committee (PAC) in the PNA through the following process:

i. Provide the PAC an opportunity to provide comments on the PNA; accordance with CalOptima Health Policy AA.1219b Provider Advisory Committee

ii. Report PNA findings to the PAC;

iii. Discuss improvement opportunities; and

6.4. Update the PAC on progress made to PNA goals.

7.5 Utilizing the PNA findings, feedback from its governing committee and regulatory guidance, CalOptima Health shall develop equity-focused interventions and build community partnerships to address the underlying factors of identified health disparities, including SDOH.

8.6. ~~PNA monitoring and reporting~~ CalOptima Health shall ~~be done~~ monitor and report on the PNA as follows:

- a. On an annual basis, CalOptima Health will ~~evaluate and~~ update the PNA. ~~CalOptima Health will and~~ submit ~~the PNA report~~ it to regulatory and/or accreditation entities as required.
- b. On an annual basis, ~~the Equity and Community~~ CalOptima Health ~~Department~~ shall submit the PNA report to the ~~PHMC who will report key findings to the~~ CalOptima Health QIHEC for the evaluation and monitoring of population health services, in accordance with CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC).
- c. CalOptima Health or a Health Network shall provide information regarding PNA findings ~~and workplan~~ to its governing committees, boards as appropriate, and Providers to support the appropriate delivery of health ~~education, in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs Assessment and Population Health Management Strategy and services, in accordance with~~ CalOptima Health Policy EE.1103: Provider Network Training.

9. ~~Local Health Department Collaboration (LHDs)~~

- C. CalOptima Health, ~~as required by DHCS,~~ will meaningfully participate ~~shall meet local planning requirements through meaningful participation~~ in Orange County Health Care Agency's (OCHCA) CHA/CHIP process ~~in accordance with the DHCS CalAIM: PHM Policy Guide.~~

~~1.~~

~~2.~~ Meaningful participation ~~may include~~ includes, but is not limited to, funding, ~~and/or in-kind~~ staffing, ~~attendance at key CHA/CHIP meetings,~~ data ~~exchange, other relevant functions.~~

~~3.~~

~~4.1.~~ CalOptima Health will ~~collaboratesharing, and/or coordination~~ with other Managed Care Plans (MCPs) operating in the same service area, ~~and OCHCA to maximize resources and foster a unified participation planning process.~~

- a. ~~CalOptima Health shall report LHJ collaborations and findings from the CHA/CHIP to the MAC~~

~~5.~~ CalOptima Health shall ~~obtain~~engage the MAC and PAC in the CHA/CHIP process, including ~~reporting on findings, obtaining~~ input/advice from the MAC on how to utilize the CHA/CHIP findings to influence/ ~~to~~ develop strategies and workstreams.

~~6.~~

~~7.1.~~ Health Equity Promotion, building

~~8.1.~~

~~9.2.~~ CalOptima Health will incorporate the CHA/CHIP in PNA findings, build community partnerships, and ~~improve~~improving Member participation ~~to fully understand the barriers preventing all populations from receiving care and preventive services as well as SDOH in solutions that advance health equity.~~

D. ~~Gathering Member Information~~

1 D. CalOptima Health shall gather Member information to identify each Member's needs and
2 understand their risk in accordance with the following requirements:
3

- 4 1. CalOptima Health will use ~~an~~ a Risk Segmentation and Stratification (RSS) methodology and/or
5 assessments and reassessments to identify each Member's health and Social Needs, as well as
6 their health goals and preferences.
7
- 8 2. ~~CalOptima Health will leverage~~ The RSS shall align with regulatory and accreditation standards
9 and integrate a broad set of internal and external data from multiple sources in the RSS
10 methodology which includesincluding, but ~~is~~ not limited to:
11
- 12 ~~a. Managed care and fee for service medical and dental claims and encounters;~~
13
14 ~~b. Screenings and assessments;~~
15
16 ~~c. Race, ethnic, and language information;~~
17
18 ~~a. Sexual orientation~~ Medi-Cal Connect;
19
20 ~~d. Medical and gender identity;~~
21
22 ~~e. Disability status;~~
23
24 ~~f. Admissions, discharge and transfer (ADT) data;~~
25
26 ~~g. Referrals and authorizations;~~
27
28 ~~h. Behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT),~~
29 ~~medications for addiction treatment, and other Substance Use Disorders (SUD) and other~~
30 ~~non-specialty mental health services information;~~
31
32 ~~i. b. County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery~~
33 ~~System (DMC-ODS), and Specialty Mental Health System (SMHS) information; claims or~~
34 ~~encounters;~~
35
36 ~~j. c. Pharmacy claims, encounters;~~
37
38 ~~k. d. Laboratory results;~~
39
40 ~~l. Housing status utilizing International Statistical Classification of Diseases and Related~~
41 ~~Health Problems, 10th Revision (ICD-10) Z-code;~~
42 e. Health appraisals, screenings and assessments;
43
- 44 Electronic Health Records (EHR)
45 ~~m. For Members under twenty-one (21), developmental and Adverse Childhood Experiences~~
46 ~~(ACEs) screenings;~~
47
48 f. Additional data when made available through fully operational from network practitioners or
49 providers;
50
51 g. Data from relevant CalOptima Health or Health Network programs, including Utilization
52 Management, Case Management, or Quality Improvement initiatives;
53

- h. Health Information Exchanges (HIE), including DHCS Medi-Cal Connect ~~service~~ and incorporated in CalOptima Health/or regional, community, or health system HIE;
- i. Advanced data sources, including the California Immunization Registry (CAIR);
- j. Findings from the PNA, including additional demographic and social needs data, including race, ethnicity, and language information, sexual orientation and gender identity; disability status; admissions, discharge, and transfer (ADT) data; referrals and authorizations; housing status; and other information, as available.

3. The ~~gathering~~RSS process shall meet the following requirements:

- a. Avoid and reduce biases to prevent exacerbation of health disparities by continuously monitoring key performance indicators, RSS outputs, and health disparities over time, and adjusting methodologies as needed.
 - b. Make ongoing, reasonable efforts to identify variables that measure or rely on race, color, national origin, sex, age, or disability, explicitly or implicitly, and mitigate the risk of bias and/or discriminatory outcomes, including in eligibility, prioritization, and predictive scoring.
 - c. Report ~~and~~ RSS performance, key performance indicators, and identified disparities to QIHEC or one of its subcommittees at least annually.
 - d. Document the RSS methodology, design and findings of the bias assessment, within CalOptima Health's PHM Strategy. This documentation will be reviewed and updated at least annually.
 - e. Stratify Members during each of the following time frames:
 - i. Upon each Member's enrollment;
 - ii. At least annually after each Member's enrollment;
 - iii. Upon significant change in health status or level of care of the Mmember; and
 - iv. Upon receipt of new information, CalOptima Health determines as potentially changing a Member's level of risk and need, which includes;
4. CalOptima Health shall use Medi-Cal Connect Risk Stratification, Segmentation, and Tiering (RSST) information to identify high-risk Medi-Cal Mmembers and conduct timely, person-centered outreach and engagement in accordance with the following requirements:
- a. CalOptima Health will ingest DHCS' monthly high-risk tier files and maintain an updated list of Mmembers requiring outreach.
 - b. During year one (2027), CalOptima Health will conduct outreach and engagement for high-risk Mmembers identified through the initial and monthly lists.
 - c. During year two (2028) and beyond, CalOptima Health will conduct outreach and engagement within 45 days of receiving high-risk updated criteria.
 - d. Outreach and engagement shall:

- i. Use two-way methods of communication, including phone, text, or other interactive methods and rely on the best available contact information, including Medi-Cal Connect's Longitudinal Member Record.
- ii. Avoid duplication of members already engaged in care management services, including but not limited to: Enhanced Care Management, Complex Case Management, or Care Coordination.
- iii. Outreach is not needed if the Member was contacted in the prior three months and needs were addressed or the Member declined services.
- iv. Outreach must support navigation, provide health education as needed, and connect Members to appropriate resources or services.
- v. Outreach efforts shall be monitored to ensure equitable engagement across all Member groups.

CalOptima Health

- ii. ~~Social services reports;~~
- iii. ~~Electronic Health Records (EHR);~~
- iv. ~~Disengaged Member reports;~~
- v. ~~County First 5 information;~~
- vi. ~~Justice involved data; and~~
- vii. ~~Homelessness Management Information System (HMIS).~~

3. Initial Screening Process

5. shall use the following initial screening processes for new or recently transitioned Members:

- a. CalOptima Health will screen newly enrolled Members by providing Health Information Form Member Evaluation Tool (HIF/MET), in accordance with CalOptima Health Policies CC.1500: Continuity of Care for Members Transitioning into CalOptima Health, and GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services.
- b. CalOptima Health shall review HIF/MET responses and provide additional outreach, Case Management, and Care Coordination activities, in accordance with CalOptima Health Policies GG.1301: Comprehensive ~~Case-Care~~ Management Process and GG.1201: Health Education Programs.
- c. Member shall receive an Initial Health Appointment (IHA), in accordance with CalOptima Health Policy GG.1613: Initial Health Appointment.
- d. Children and youth will be provided with initial screenings, in accordance with CalOptima Health Policy GG.1116: Pediatric ~~Prevention~~Preventive Services.

E. Understanding Risk

1.6. CalOptima Health will utilize shall conduct assessment and reassessment in accordance with the following to understand a Member's risk requirements:

1
2 a.— Risk Segmentation and Stratification (RSS); and

3
4 b.— Assessments and reassessments.

5
6 ~~2.— Risk Segmentation and Stratification (RSS)~~

7
8 a.— Risk stratification approach must:

9
10 i.— Align with regulatory and accreditation standards.

11
12 ii.— Include utilization data integrated with other data sources such as:

13
14 a) Findings from the PNA;

15
16 b) Clinical and behavioral data; or

17
18 e) Population and Social Needs data, and a broad range of internal and external data.

19
20 iii.— Incorporate data sources listed in Section II.C.2. of this policy to the greatest extent
21 possible.

22
23 iv.— Avoid and reduce biases to prevent exacerbation of health disparities by continuously
24 evaluating key performance indicators and RSS outputs and monitoring health
25 disparities over time.

26
27 ~~v.a.— Stratify Members during each of the following time frames:~~

28
29 a) Upon each Member's enrollment;

30
31 b) At least annually after each Member's enrollment;

32
33 e) Upon significant change in health status or level of care of the Member; and

34
35 d) Upon receipt of new information, CalOptima Health determines as potentially
36 changing a Member's level of risk and need.

37
38 vi.— CalOptima Health's RSS methodology will be continuously evaluated for effectiveness.

39
40 b.— Prior to launch of Medi-Cal Connect, CalOptima Health will:

41
42 i.— Use an RSS approach as described above in Section III.D.2.

43
44 ii.— Place members into risk tiers to identify those that should be connected to available
45 interventions and services; and

46
47 iii.— Continuously evaluate CalOptima Health's RSS methodology for effectiveness.

48
49 c.— Medi-Cal Connect will launch with two distinct implementation periods:

50
51 i.— Initial Implementation Period; and

52
53 ii.— Required Implementation Period.

1 d. ~~Initial Implementation Period~~

- 2
- 3 i. ~~Implementation Period is the period that begins with the launch of the DHCS Medi-Cal~~
- 4 ~~Connect RSS and risk tiering (RSST) functionalities and will end no earlier than July~~
- 5 ~~2026.~~
- 6
- 7 ii. ~~DHCS will provide access to the Medi-Cal Connect standardized RSST risk tiers.~~
- 8
- 9 iii. ~~CalOptima Health will continue to use CalOptima Health's RSS methodology by itself~~
- 10 ~~or in combination with the Medi-Cal Connect RSST approach through the Initial~~
- 11 ~~Implementation Period.~~
- 12
- 13 iv. ~~CalOptima Health will develop and implement internal processes and technical~~
- 14 ~~infrastructure to integrate DHCS RSST risk tiers into care management systems, and~~
- 15 ~~update policies and procedures to ensure implementation readiness.~~
- 16

17 e. ~~Required Implementation Period~~

- 18
- 19 i. ~~Required Implementation Period will begin no earlier than July 2026, and all MCPs will~~
- 20 ~~be required to use DHCS standardized RSST Tiering.~~
- 21
- 22 ii. ~~Beginning in July 2026 or earlier, CalOptima Health will integrate DHCS Medi-Cal Connect~~
- 23 ~~RSST to conduct member risk segmentation, stratification and tiering.~~
- 24
- 25 a) ~~CalOptima Health will ensure all members flagged as high risk through Medi-Cal~~
- 26 ~~Connect RSST will be assessed according to Section III.D.3 of this policy.~~
- 27
- 28 iii. ~~CalOptima Health may also continue to use real time data from local sources to connect~~
- 29 ~~Members to services and resources, as needed.~~
- 30

31 3. ~~Assessment and Reassessment~~

- 32
- 33 a. CalOptima Health, its Health Networks, and Providers will ensure assessment of the
- 34 following Members:
- 35
- 36 i. Members entering Complex Case Management, in accordance with CalOptima Health
- 37 Policy GG.1301: Comprehensive ~~Case-Care~~ Management Process.
- 38
- 39
- 40 ii. Members entering Enhanced Care Management, in accordance with CalOptima Health
- 41 Policies GG.1353: CalAIM Enhanced Care Management Services Delivery, GG.1354:
- 42 CalAIM Enhanced Care Management – Eligibility and Outreach, and GG.1356:
- 43 CalAIM Enhanced Care Management Administration.
- 44
- 45 iii. Pregnant individuals in accordance with CalOptima Health Policy GG.1701: ~~CalOptima~~
- 46 ~~Health Perinatal Support Services Program~~ Maternity Services for Pregnant and
- 47 Postpartum Members.
- 48
- 49 iv. Seniors and persons with disabilities who meet the definition of “high risk” as described
- 50 in CalOptima Health Policies GG.1323: Seniors and Persons with Disabilities and
- 51 Health Risk Assessments, and GG.1324: Seniors and Persons with Disabilities (SPD)
- 52 Comprehensive Case Management.
- 53

- b. CalOptima Health, its Health Networks, and Providers will ensure assessment and reassessment of the following Members:
- i. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)
 - ii. CalOptima Health will continue to assess Members who need LTSS using the existing standardized LTSS referral questions at least every twelve (12) months.
 - iii. Children and Youth with Special Health Care Needs (CYSHCN).

E. CalOptima Health shall provide services and supports in accordance with the following requirements:

F. For Providing Services and Supports

1. each program or service that includes interactive contact with Members, CalOptima Health shall maintain a documented process to inform eligible Members of:
 - a. How the Member became eligible to participate in the program or service;
 - b. How to use the program or service; and
 - c. How to opt in or opt out, as applicable.
2. For purposes of Member notification, interactive contact may include, but is not limited to, telephone outreach, text messaging, secure electronic messaging, live chat, video conference, in-person contact, or interactive web-based communication.
3. CalOptima Health and Health Networks shall ensure that Member notification materials and workflows for interactive-contact programs are documented and implemented in a manner that can be operationalized and evidenced for regulatory and accreditation review.
4. CalOptima Health's PHM program ensures Member ~~support~~ supports and services are delivered according to Member's risk, assessment and reassessment needs through the following:
 - a. Basic Population Health Management (BPHM);
 - b. Care Management Programs;
 - c. Enhanced Care Management (ECM); and
 - d. Transitional Care Services (TCS).

2.5 Basic Population Health Management (BPHM)

- a. BPHM is a collaborative process that ensures ~~all~~ Members have access to:
 - i. Primary Care services in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition Role, and Responsibilities:

- a) BPHM ~~will identify~~identifies Members who are not using Primary Care through utilization and enrollment data stratified by race, ethnicity, and language for outreach to ensure Member engagement with Members assigned PCPs.
- ii. Coordination of care and ~~Referrals~~referrals for medical, carved out, linked, and Community Supports, ensuring members' full range of health and health-related needs are addressed across the delivery system.
- iii. Annual screenings for unmet food, housing, and transportation needs, using one or more validated screening instruments. Based on the results of the screenings, members will be linked to appropriate health-related social support and services.
- iii-iv. Community Health ~~Workers (CHW)~~Worker services (Medi-Cal Only) to address health-related social needs, promote wellness and prevention, support chronic disease self-management, and advance maternal and child health outcomes in accordance with CalOptima Health PHM Strategy and CalOptima Health Policy GG.1213: Community Health Workers.
- iv.—
- v. ~~Wellness~~Comprehensive health promotion, wellness and prevention programs in accordance with CalOptima Health Policy GG.1201: Health Education Programs.
- vi. Diabetes Prevention Program in accordance with CalOptima Health Policy GG.1202.
- vi-vii. Self-management tools in accordance with CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools, and provide at a minimum information on the following areas:
- a) Healthy weight (BMI) maintenance;
- b) Smoking and tobacco use cessation;
- c) Encouraging physical activity;
- d) Healthy eating;
- e) Managing stress;
- f) Avoiding at-risk drinking; and
- g) Identifying depressive symptoms.
- vii-viii. Disease Management ~~programs~~services in alignment~~accordance~~ with ~~regulatory requirements at a minimum.~~CalOptima Health Policy GG.1708.
- ~~a) These programs will incorporate health education interventions, identify Members for engagement and seek to close care gaps with a focus on improving equity and reducing health disparities.~~
- b) ~~The Disease Management programs will address at a minimum the following conditions:~~
- i) ~~Diabetes;~~

1
2 ii) ~~Cardiovascular disease;~~

3
4 iii) ~~Asthma; and~~

5
6 iv) ~~Depression.~~

7
8 ~~viii-ix.~~ Programs to address maternal health outcomes including access to prenatal and
9 postpartum care, in accordance with CalOptima Health Policy GG.1701: ~~CalOptima~~
10 ~~Health Perinatal Support~~ Maternity Services Program for Pregnant and Postpartum
11 Members

12
13 ~~ix.~~ ~~CalOptima Health will develop strategies to address different utilization patterns in~~
14 ~~accordance with CalOptima Health Policy GG.1532: Over and Under Utilization~~
15 ~~Monitoring.~~

16
17 x. PHM for children that ensure all children under twenty-one (21) years of age with full
18 scope Medi-Cal status will receive appropriate preventive, mental health,
19 developmental and specialty EPSDT in accordance with CalOptima Health Policy
20 GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

21
22 b. CalOptima Health will monitor and develop strategies to address different utilization
23 patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization
24 Monitoring.

25
26 ~~b-c.~~ CalOptima Health's BPHM services will promote Health Equity and align with National
27 Standards for Culturally and Linguistically Appropriate Services (CLAS).

28
29 ~~e-d.~~ BPHM will be provided to Members enrolled in ECM by the ECM Provider.

30
31 3.6. Care Management Programs

32
33 a. Complex Care Management (CCM)

34
35 i. CalOptima Health CCM services are provided to Members as mandated by federal and
36 state regulations, and in accordance with CalOptima Health Policy GG.1301:
37 Comprehensive ~~Case-Care~~ Management Process, and CC.2100 CalOptima Health
38 Covered Health Assessment and Case Management.

39
40 ii. Member eligibility is determined by CalOptima Health's RSS process and in
41 accordance with CalOptima Health Policy GG.1301: Comprehensive ~~Case-Care~~
42 Management Process.

43
44 iii. CCM is provided to Members under the age of twenty-one (21) in accordance with
45 CalOptima Health Policies GG.1330: Case Management - California Children's
46 Services Program/Whole-Child Model, and GG.1121: Early and Periodic Screening,
47 Diagnosis and Treatment (EPSDT) Services.

48
49 b. Enhanced Care Management (ECM)

50
51 i. CalOptima Health ECM services address the clinical and nonclinical needs of the
52 highest-need Members through intensive coordination of health and health-related
53 services, in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced
54 Care Management Services Delivery, GG.1354: CalAIM Enhanced Care Management

– Eligibility and Outreach, and GG.1356: CalAIM Enhanced Care Management Administration.

ii. Members cannot be enrolled in ECM and CCM at the same time.

c. Transitional Care Services (TCS)

i. CalOptima Health and Health Networks will provide TCS for Members transferring from one setting or level of care to another, in accordance with CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS).

G.F. Coordination of Services and Resources for Members

1. CalOptima Health will coordinate services and connect Members to resources with Third Party Entities in accordance with CalOptima Health Policy EE.1144: Memorandum of Understanding (MOU) Requirements for CalOptima Health and Third-Party Entities.
2. ~~By July 2025~~, CalOptima Health will establish relationships and processes to conduct closed loop referrals in accordance with the addendum to the DHCS PHM Policy Guide: Closed Loop Referral Implementation Guidance.
3. ~~By January 1, 2025~~, CalOptima Health will coordinate warm handoffs with local health agencies and other public benefits programs including, but not limited to:
 - a. Orange County Health Care Agency
 - b. CalFresh
 - c. CalWORKs
 - d. Early Start
 - e. Supplemental Security Income

G. Practitioner or Provider Collaboration and Support

1. CalOptima Health supports practitioners or providers in its network to achieve population health management goals by:
 - a. Providing practice transformation support to primary care practitioners;
 - b. Providing comparative quality information on selected specialties; and
 - c. Defining roles and responsibilities to achieve collaborative care management with provider partners.

H. Data Sharing with Practitioners and Providers

- 4.1. CalOptima Health shall share data with participating practitioners and providers to support population health management, including at a minimum:
 - a. Case management data for Members receiving case management services;

b. Utilization data to support follow-up and Member engagement; and

c. Quality performance data on agreed-upon measures.

2. For each data type, the documented process shall identify:

a. Rthe recipient(s);

b. the mMethod of sharing; and

c. the fFrequency of sharing.

3. CalOptima Health shall retain documentation demonstrating at least one instance of sharing for each data type.

4. Data sharing shall be conducted in accordance with applicable privacy and security requirements.

III. CalOptima Health

A. I. shall evaluate the PHM Program using Key Performance Indicators (KPIs) and PHM Program evaluation in accordance with the following requirements:

1. CalOptima Health will assess the Develop and use KPIs to continuously monitor and report on the implementation, operations, and effectiveness of the PHM Program to understand.

1-2. Conduct an analysis, at least annually, of the impact on outcomes and Health Equity over time of its PHM Strategy that includes:

III.

a. Quantitative results for at least four (4) measures, including clinical, cost/utilization, and member feedback/experience;

b. Comparison of results to a benchmark or goal; and

c. Interpretation of results, including qualitative analysis of how goals were met or not met.

3. Using the results of the PHM impact analysis, CalOptima Health will develop KPIs in alignment with the DHCS shall, at least annually, identify and act upon at least two opportunities for improvement.

4. On an annual basis, CalOptima Health shall submit the PHM impact analysis to the QIHEC to share its findings and identify opportunities for future improvement efforts.

1. When CalOptima Health delegates PHM Program Guide requirements to continuously monitor and report on the PHM Program performance activities to a Health Network or other delegated entity, oversight shall be conducted in accordance with CalOptima Health Policy GG.-1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- 1
- 2 A. CalOptima Health Comprehensive Wellness Program for Members under Twenty-One
- 3 B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- 4 C. CalOptima Health Policy AA.1219a: Member Advisory Committee
- 5 D. CalOptima Health Policy AA.1219b: Provider Advisory Committee
- 6 E. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima
- 7 Health
- 8 ~~C.F.~~ CalOptima Health Policy EE.1103: Provider Network Training
- 9 ~~D.G.~~ CalOptima Health Policy EE.1144: Memorandum of Understanding (MOU) Requirements for
- 10 CalOptima Health and Third-Party Entities
- 11 ~~E.H.~~ CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and
- 12 Responsibilities
- 13 ~~F.I.~~ CalOptima Health Policy GG.1116: Pediatric Prevention Services
- 14 ~~G.J.~~ CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment
- 15 (EPSDT) Services
- 16 ~~H.K.~~ CalOptima Health Policy GG.1130: Community Based Adult Services (CBAS) Eligibility,
- 17 Authorization, Availability, and Care Coordination Processes
- 18 ~~I.L.~~ CalOptima Health Policy GG.1201: Health Education Programs
- 19 ~~J.M.~~ CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools
- 20 ~~K.N.~~ CalOptima Health Policy GG.1213: Community Health Worker Services
- 21 ~~L.O.~~ CalOptima Health Policy GG.1301: Comprehensive Care Management Process
- 22 ~~M.P.~~ CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk
- 23 Assessments
- 24 ~~N.Q.~~ CalOptima Health Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive
- 25 Case Management
- 26 ~~O.R.~~ CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima
- 27 Health Services
- 28 ~~P.S.~~ CalOptima Health Policy GG.1330: Case Management – California Children’s Services
- 29 Program/Whole-Child Model
- 30 ~~Q.T.~~ CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery
- 31 ~~R.U.~~ CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and
- 32 Outreach
- 33 ~~S.V.~~ CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration
- 34 ~~T.W.~~ CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services
- 35 (TCS)
- 36 ~~U.X.~~ CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
- 37 Y. CalOptima Health Policy GG.1613: Initial Health Appointment
- 38 V-Z. CalOptima Health Policy GG.1619: Delegation Oversight
- 39 ~~W-AA.~~ CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC)
- 40 ~~X-BB.~~ CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Maternity
- 41 Services (PSS) Program for Pregnant and Postpartum Members
- 42 ~~Y-CC.~~ CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to,
- 43 Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
- 44 ~~Z-DD.~~ CalOptima Health Policy GG.1803: Authorization Process and Criteria for Admission to,
- 45 Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
- 46 ~~AA-EE.~~ CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-
- 47 of-Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
- 48 ~~BB-FF.~~ CalOptima Health Policy GG.1808: Plan of Care, Long-Term Care
- 49 ~~CC-GG.~~ CalOptima Health Policy GG.1830: In-Home Supportive Services (IHSS) Referral
- 50 Coordination Process
- 51 ~~DD-HH.~~ CalOptima Health Policy GG.1832: Multipurpose Senior Services Program (MSSP) - MSSP
- 52 Identification, Referral, and Coordination of Care Process
- 53 ~~EE-II.~~ CalOptima Health Policy GG.1900: Behavioral Health Services

~~FF.JJ.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005: No Wrong Door for Mental Health Services Policy

~~GG.KK.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Program Guide (Supersedes APLs 17-012 and 17-013)

~~HH.LL.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030: Initial Health Appointment (Supersedes APL 13-017 and Policy Letters 13-001 and 08-003)

~~I.MM.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004: Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)

~~J.NN.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs Assessment and Population Health Management Strategy (Supersedes APL 19-011)

~~KK.OO.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 25-009: Community Advisory Committee

~~LL.PP.~~ Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, July 2025

~~MM.QQ.~~ Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

~~NN.RR.~~ National Committee for Quality Assurance Standards and Guidelines

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/29/2023	Department of Health Care Services (DHCS)	File and Use
08/15/2024	Department of Health Care Services (DHCS)	Approved as Submitted
11/12/2025	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
06/01/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	07/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	10/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	07/01/2024	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	11/01/2025	GG.1667	CalAIM Population Health Management Program	Medi-Cal
<u>Revised</u>		<u>GG.1667</u>	<u>Population Health Management Program</u>	<u>Covered California Medi-Cal</u>

IX. GLOSSARY

Term	Definition
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Care Manager	An individual identified as a single point of contact responsible for the provision of care management services for a member.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Children and Youth with Special Health Care Needs (CYSHCN)	Children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CYSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Complex Case Management (CCM)	The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medical Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.

Term	Definition
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than twenty-one (21) years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
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.
Long Term Services and Supports (LTSS)	Services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services.
Medi-Cal Connect	An innovative statewide data solution to drive population health management (PHM), close gaps in services, and improve Member lives.
Member	<u>Covered California: 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.</u> <u>Medi-Cal: 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.</u>
Memorandum of Understanding (MOU)	An agreement between CalOptima Health and an external agency, which delineates responsibilities for coordinating care for Members.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Population Health Management (PHM)	A whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

Term	Definition
Population Health Management Committee (PHMC)	An advising committee that: 1. Provides overall direction for continuous process improvement and oversight of the Population Health Management (PHM) Program; 2. Ensures PHM activities are consistent with CalOptima Health's strategic goals and priorities; and 3. Monitors compliance with regulatory requirements.
Population Health Management Strategy (PHMS)	A comprehensive plan of action for addressing Member needs across the continuum of care, based on annual Population Needs Assessment (PNA) results, data driven risk stratification, predictive analysis, identified gaps in care, standardized assessment processes, and holistic care management interventions. CalOptima Health is required to include, at a minimum, a description of how it will: 1. Keep all Members healthy by focusing on wellness and prevention services; 2. Identify and manage Members with high and rising-risk; 3. a separate section on Members less than twenty-one (21) years of age; 4. Ensure effective transition planning, across delivery systems or settings, through care coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for Member; and 5. Identify and mitigate Member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance Health Equity.
Population Needs Assessment (PNA)	A process for: 1. Identifying Member health needs and Health Disparities; 2. Evaluating health education, Cultural and Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and 3. Implementing targeted strategies for health education, C&L, and QI programs and services.
Primary Care	A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to Specialty Care Provider focusing on specific needs.
Primary Care Practitioner/Physician (PCP)	A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
Prior Authorization	<u>Covered California: 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).</u> <u>Medi-Cal:</u> A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

Term	Definition
Provider	<u>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.</u> <u>Medi-Cal:</u> 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.
Referral	The process of a Provider directing a Member to another Provider for care and or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Risk Stratification	A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.
Risk Stratification and Segmentation (RSS)	The process of separating member populations into different risk groups and/or meaningful subsets using information collected through population assessments and other data sources. RSS results in the categorization of members with care needs at all levels and intensities.
Risk Tiering	The assigning of members to standard risk tiers (i.e., high, medium-rising, or low), with the goal of determining appropriate care management programs or specific services.
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. Also known as, Health Related Social Needs.
Social Needs	Non-clinical needs relating to institutions or functioning of humans in society to meet basic needs such as relationships, mental health status, or the needs for food and shelter.
Third Party Entities	Local health departments, local educational and governmental agencies, such as county behavioral health departments for specialty mental health care and SUD services, and other local programs and services.
Transitional Care Services	Services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).

Policy: GG.1667
Title: **Population Health Management Program**
Department: Case Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 06/01/2023
Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy defines CalOptima Health's Population Health Management (PHM) Program and describes the process by which CalOptima Health, Health Networks, and Providers engage Members across delivery systems to identify health needs, stratify risk, and deliver coordinated interventions that improve health outcomes, reduce disparities, and promote Health Equity across the continuum of care.

II. POLICY

- A. CalOptima Health shall establish and maintain a PHM Program in accordance with the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) requirements.
- B. The PHM Program shall align with the National Committee for Quality Assurance (NCQA) Health Plan and Health Outcomes Accreditation standards.
- C. The PHM Program ensures that all Members have access to a comprehensive set of services based on their individual needs and preferences across the continuum of care, which promotes improved outcomes, and Health Equity.
- D. The goals of the PHM Program are to:
 1. Build trust and meaningful engagement with Members;
 2. Provide interventions to support health and wellness for all Members;
 3. Utilize data-driven Risk Stratification, standardized assessment processes and predictive analytics to address gaps in care;
 4. Provide Care Management services for Members with increased risk of poor health outcomes;
 5. Identify and mitigate Social Drivers of Health (SDOH) to reduce disparities; and
 6. Address upstream factors by linking Members to public health and social services.

III. PROCEDURE

A. CalOptima Health shall develop an annual PHM Strategy that meets the following requirements:

1. The PHM Strategy is a comprehensive, accountable plan of action for addressing Member needs and preferences.
2. The PHM Strategy outlines the PHM Program, including the following areas of focus:
 - a. Keeping Members healthy;
 - b. Managing Members with emerging risk;
 - c. Patient safety or outcomes across settings; and
 - d. Managing multiple chronic illnesses.
3. The PHM Strategy describes the following for each area of focus:
 - a. A measurable, timebound goal and population of focus;
 - b. Programs or services offered;
 - c. At least three activities that support practitioners, providers, or community-based organizations;
 - d. How Member programs are coordinated across settings, providers, and levels of care;
 - e. How Members and practitioners are informed of available PHM programs and services; and
 - f. Describes the organization's commitment and strategies to address identified disparities.
4. The PHM Strategy prioritizes strong ties to the community and incorporates strategies and interventions that address findings from the Population Needs Assessment (PNA) and the Orange County Health Care Agency's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP); and
 - a. Incorporates cross-sector strategies to improve health in the neighborhoods and communities where Members reside, especially those with poor health outcomes;
 - b. Aligns with quality improvement efforts identified by DHCS, DMHC, and the Centers for Medicare and Medicaid Services (CMS).
5. Annually, CalOptima Health will update the PHM Strategy and submit it to regulatory and/or accreditation entities as required.
6. The CalOptima Health Quality Improvement and Health Equity Committee (QIHEC) shall provide oversight and monitor the PHM Strategy on a quarterly basis and report to the Board of Directors Quality Assurance Committee (QAC).

B. CalOptima Health shall develop an annual Population Needs Assessment (PNA) that meets the following requirements:

- 1 1. Is conducted in accordance with NCQA to gather and evaluate population-level data related to
2 the health of its Members, including:
3
4 a. Characteristics and needs;
5
6 b. Social Drivers of Health (SDOH);
7
8 c. Needs of children and adolescents;
9
10 d. Members with disabilities, Serious Mental Illness (SMI) or serious emotional disturbance;
11
12 e. Member of racial or ethnic groups
13
14 f. Members with Limited English Proficiency (LEP); and
15
16 g. At least two characteristics or needs for two other relevant subpopulations distinct from
17 those listed above.
18
19 2. CalOptima Health will use reliable data sources to identify Member health needs and health
20 disparities. This process will include analyzing data to identify the differences in health
21 outcomes, quality of care, and utilization, as well as the potential root causes of these
22 disparities.
23
24 3. Based on PNA findings, CalOptima Health will review community resources for integration
25 into PHM program offerings and update the PHM Strategy, including programs, services,
26 activities, and resources.
27
28 4. CalOptima Health shall have a process to obtain stakeholder feedback on PNA findings and/or
29 improvement opportunities. Stakeholders may include, but not be limited to, the Member
30 Advisory Committee (MAC) in accordance with CalOptima Health Policy AA.1219a Member
31 Advisory Committee and Provider Advisory Committee (PAC) in accordance with CalOptima
32 Health Policy AA.1219b Provider Advisory Committee.
33
34 5. Utilizing the PNA findings, feedback from its governing committee and regulatory guidance,
35 CalOptima Health shall develop equity-focused interventions and build community partnerships
36 to address the underlying factors of identified health disparities, including SDOH.
37
38 6. CalOptima Health shall monitor and report on the PNA as follows:
39
40 a. On an annual basis, CalOptima Health will update the PNA and submit it to regulatory
41 and/or accreditation entities as required.
42
43 b. On an annual basis, CalOptima Health shall submit the PNA report to the QIHEC for the
44 evaluation and monitoring of population health services, in accordance with CalOptima
45 Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC).
46
47 c. CalOptima Health or a Health Network shall provide information regarding PNA findings
48 to its governing committees, boards as appropriate, and Providers to support the appropriate
49 delivery of health services, in accordance with CalOptima Health Policy EE.1103: Provider
50 Network Training.
51
52 C. CalOptima Health shall meet local planning requirements through meaningful participation in
53 Orange County Health Care Agency's (OCHCA) CHA/CHIP process.
54

1. Meaningful participation includes, but is not limited to, funding and/or in-kind staffing, attendance at key CHA/CHIP meetings, data sharing, and/or coordination with other Managed Care Plans (MCPs) operating in the same service area.
 2. CalOptima Health shall engage the MAC and PAC in the CHA/CHIP process, including reporting on findings, obtaining input to develop strategies, building community partnerships, and improving Member participation in solutions that advance health equity.
- D. CalOptima Health shall gather Member information to identify each Member's needs and understand their risk in accordance with the following requirements:
1. CalOptima Health will use a Risk Segmentation and Stratification (RSS) methodology and/or assessments and reassessments to identify each Member's health and Social Needs, as well as their health goals and preferences.
 2. The RSS shall align with regulatory and accreditation standards and integrate a broad set of internal and external data from multiple sources including, but not limited to:
 - a. Medi-Cal Connect;
 - b. Medical and behavioral health claims or encounters;
 - c. Pharmacy claims, encounters;
 - d. Laboratory results;
 - e. Health appraisals, screenings and assessments;
 - f. Electronic Health Records (EHR) data from network practitioners or providers;
 - g. Data from relevant CalOptima Health or Health Network programs, including Utilization Management, Case Management, or Quality Improvement initiatives;
 - h. Health Information Exchanges (HIE), including DHCS Medi-Cal Connect and/or regional, community, or health system HIE;
 - i. Advanced data sources, including the California Immunization Registry (CAIR);
 - j. Findings from the PNA, including additional demographic and social needs data, including race, ethnicity, and language information, sexual orientation and gender identity; disability status; admissions, discharge, and transfer (ADT) data; referrals and authorizations; housing status; and other information, as available.
 3. The RSS process shall meet the following requirements:
 - a. Avoid and reduce biases to prevent exacerbation of health disparities by continuously monitoring key performance indicators, RSS outputs, and health disparities over time, and adjusting methodologies as needed.
 - b. Make ongoing, reasonable efforts to identify variables that measure or rely on race, color, national origin, sex, age, or disability, explicitly or implicitly, and mitigate the risk of bias and/or discriminatory outcomes, including in eligibility, prioritization, and predictive scoring.

- 1 c. Report RSS performance, key performance indicators, and identified disparities to QIHEC
2 or one of its subcommittees at least annually.
3
4 d. Document the RSS methodology, design and findings of the bias assessment, within
5 CalOptima Health's PHM Strategy. This documentation will be reviewed and updated at
6 least annually.
7
8 e. Stratify Members during each of the following time frames:
9
10 i. Upon each Member's enrollment;
11
12 ii. At least annually after each Member's enrollment;
13
14 iii. Upon significant change in health status or level of care of the Member; and
15
16 iv. Upon receipt of new information, CalOptima Health determines as potentially changing
17 a Member's level of risk and need.
18
19 4. CalOptima Health shall use Medi-Cal Connect Risk Stratification, Segmentation, and Tiering
20 (RSST) information to identify high-risk Medi-Cal Members and conduct timely,
21 person-centered outreach and engagement in accordance with the following requirements:
22
23 a. CalOptima Health will ingest DHCS' monthly high-risk tier files and maintain an updated
24 list of Members requiring outreach.
25
26 b. During year one (2027), CalOptima Health will conduct outreach and engagement for high-
27 risk Members identified through the initial and monthly lists.
28
29 c. During year two (2028) and beyond, CalOptima Health will conduct outreach and
30 engagement within 45 days of receiving high-risk updated criteria.
31
32 d. Outreach and engagement shall:
33
34 i. Use two-way methods of communication, including phone, text, or other interactive
35 methods and rely on the best available contact information, including Medi-Cal
36 Connect's Longitudinal Member Record.
37
38 ii. Avoid duplication of members already engaged in care management services, including
39 but not limited to Enhanced Care Management, Complex Case Management, or Care
40 Coordination.
41
42 iii. Outreach is not needed if the Member was contacted in the prior three months and
43 needs were addressed or the Member declined services.
44
45 iv. Outreach must support navigation, provide health education as needed, and connect
46 Members to appropriate resources or services.
47
48 v. Outreach efforts shall be monitored to ensure equitable engagement across all Member
49 groups.
50
51 5. CalOptima Health shall use the following initial screening processes for new or recently
52 transitioned Members:
53

- 1 a. CalOptima Health will screen newly enrolled Members by providing Health Information
2 Form Member Evaluation Tool (HIF/MET), in accordance with CalOptima Health
3 Policies CC.1500: Continuity of Care for Members Transitioning into CalOptima Health,
4 and GG.1325: Continuity of Care for Members Transitioning into CalOptima Health
5 Services.
6
7 b. CalOptima Health shall review HIF/MET responses and provide additional outreach, Case
8 Management, and Care Coordination activities, in accordance with CalOptima Health
9 Policies GG.1301: Comprehensive Care Management Process and GG.1201: Health
10 Education Programs.
11
12 c. Member shall receive an Initial Health Appointment (IHA), in accordance with
13 CalOptima Health Policy GG.1613: Initial Health Appointment.
14
15 d. Children and youth will be provided with initial screenings, in accordance with CalOptima
16 Health Policy GG.1116: Pediatric Preventive Services.
17
18 6. CalOptima Health shall conduct assessment and reassessment in accordance with the following
19 requirements:
20
21 a. CalOptima Health, its Health Networks, and Providers will ensure assessment of the
22 following Members:
23
24 i. Members entering Complex Case Management, in accordance with CalOptima Health
25 Policy GG.1301: Comprehensive Care Management Process.
26
27 ii. Members entering Enhanced Care Management, in accordance with CalOptima Health
28 Policies GG.1353: CalAIM Enhanced Care Management Services Delivery, GG.1354:
29 CalAIM Enhanced Care Management – Eligibility and Outreach, and GG.1356:
30 CalAIM Enhanced Care Management Administration.
31
32 iii. Pregnant individuals in accordance with CalOptima Health Policy GG.1701: Maternity
33 Services for Pregnant and Postpartum Members.
34
35 iv. Seniors and persons with disabilities who meet the definition of “high risk” as described
36 in CalOptima Health Policies GG.1323: Seniors and Persons with Disabilities and
37 Health Risk Assessments, and GG.1324: Seniors and Persons with Disabilities (SPD)
38 Comprehensive Case Management.
39
40 b. CalOptima Health, its Health Networks, and Providers will ensure assessment and
41 reassessment of the following Members:
42
43 i. Those with long-term services and supports (LTSS) needs (as required by federal and
44 state law and waiver)
45
46 ii. CalOptima Health will continue to assess Members who need LTSS using the existing
47 standardized LTSS referral questions at least every twelve (12) months.
48
49 iii. Children and Youth with Special Health Care Needs (CYSHCN).
50
51 E. CalOptima Health shall provide services and supports in accordance with the following
52 requirements:
53

1. For each program or service that includes interactive contact with Members, CalOptima Health shall maintain a documented process to inform eligible Members of:
 - a. How the Member became eligible to participate in the program or service;
 - b. How to use the program or service; and
 - c. How to opt in or opt out, as applicable.
2. For purposes of Member notification, interactive contact may include, but is not limited to, telephone outreach, text messaging, secure electronic messaging, live chat, video conference, in-person contact, or interactive web-based communication.
3. CalOptima Health and Health Networks shall ensure that Member notification materials and workflows for interactive-contact programs are documented and implemented in a manner that can be operationalized and evidenced for regulatory and accreditation review.
4. CalOptima Health's PHM program ensures Member supports and services are delivered according to Member's risk, assessment and reassessment needs through the following:
 - a. Basic Population Health Management (BPHM);
 - b. Care Management Programs;
 - c. Enhanced Care Management (ECM); and
 - d. Transitional Care Services (TCS).
5. Basic Population Health Management (BPHM)
 - a. BPHM is a collaborative process that ensures Members have access to:
 - i. Primary Care services in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition Role, and Responsibilities:
 - a) BPHM identifies Members who are not using Primary Care through utilization and enrollment data stratified by race, ethnicity, and language for outreach to ensure Member engagement with Members assigned PCPs.
 - ii. Coordination of care and referrals for medical, carved out, linked, and Community Supports, ensuring members' full range of health and health-related needs are addressed across the delivery system.
 - iii. Annual screenings for unmet food, housing, and transportation needs, using one or more validated screening instruments. Based on the results of the screenings, members will be linked to appropriate health-related social support and services.
 - iv. Community Health Worker services (Medi-Cal Only) to address health-related social needs, promote wellness and prevention, support chronic disease self-management, and advance maternal and child health outcomes in accordance with Policy GG.1213: Community Health Workers.
 - v. Comprehensive health promotion, wellness, and prevention programs in accordance with CalOptima Health Policy GG.1201: Health Education Programs.

- vi. Diabetes Prevention Program in accordance with CalOptima Health Policy GG.1202.
- vii. Self-management tools in accordance with CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools, and provide at a minimum information on the following areas:
- a) Healthy weight (BMI) maintenance;
 - b) Smoking and tobacco use cessation;
 - c) Encouraging physical activity;
 - d) Healthy eating;
 - e) Managing stress;
 - f) Avoiding at-risk drinking; and
 - g) Identifying depressive symptoms.
- viii. Disease Management services in accordance with CalOptima Health Policy GG.1708.
- ix. Programs to address maternal health outcomes including access to prenatal and postpartum care, in accordance with CalOptima Health Policy GG.1701: Maternity Services for Pregnant and Postpartum Members
- x. PHM for children that ensure all children under twenty-one (21) years of age with full scope Medi-Cal status will receive appropriate preventive, mental health, developmental and specialty EPSDT in accordance with CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.
- b. CalOptima Health will monitor and develop strategies to address different utilization patterns in accordance with CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring.
- c. CalOptima Health's BPHM services will promote Health Equity and align with National Standards for Culturally and Linguistically Appropriate Services (CLAS).
- d. BPHM will be provided to Members enrolled in ECM by the ECM Provider.
6. Care Management Programs
- a. Complex Care Management (CCM)
- i. CalOptima Health CCM services are provided to Members as mandated by federal and state regulations, and in accordance with CalOptima Health Policy GG.1301: Comprehensive Care Management Process and CC.2100 CalOptima Health Covered Health Assessment and Case Management.
 - ii. Member eligibility is determined by CalOptima Health's RSS process and in accordance with CalOptima Health Policy GG.1301: Comprehensive Care Management Process.

1 iii. CCM is provided to Members under the age of twenty-one (21) in accordance with
2 CalOptima Health Policies GG.1330: Case Management - California Children's
3 Services Program/Whole-Child Model, and GG.1121: Early and Periodic Screening,
4 Diagnosis and Treatment (EPSDT) Services.

5
6 b. Enhanced Care Management (ECM)
7

8 i. CalOptima Health ECM services address the clinical and nonclinical needs of the
9 highest-need Members through intensive coordination of health and health-related
10 services, in accordance with CalOptima Health Policies GG.1353: CalAIM Enhanced
11 Care Management Services Delivery, GG.1354: CalAIM Enhanced Care Management
12 – Eligibility and Outreach, and GG.1356: CalAIM Enhanced Care Management
13 Administration.
14

15 ii. Members cannot be enrolled in ECM and CCM at the same time.
16

17 c. Transitional Care Services (TCS)
18

19 i. CalOptima Health and Health Networks will provide TCS for Members transferring
20 from one setting or level of care to another, in accordance with CalOptima Health
21 Policy GG.1357: Population Health Management Transitional Care Services (TCS).
22

23 F. Coordination of Services and Resources for Members
24

- 25 1. CalOptima Health will coordinate services and connect Members to resources with Third Party
26 Entities in accordance with CalOptima Health Policy EE.1144: Memorandum of Understanding
27 (MOU) Requirements for CalOptima Health and Third-Party Entities.
28
29 2. CalOptima Health will establish relationships and processes to conduct closed loop referrals in
30 accordance with the addendum to the DHCS PHM Policy Guide: Closed Loop Referral
31 Implementation Guidance.
32
33 3. CalOptima Health will coordinate warm handoffs with local health agencies and other public
34 benefits programs including, but not limited to:
35
36 a. Orange County Health Care Agency
37
38 b. CalFresh
39
40 c. CalWORKs
41
42 d. Early Start
43
44 e. Supplemental Security Income
45

46 G. Practitioner or Provider Collaboration and Support
47

- 48 1. CalOptima Health supports practitioners or providers in its network to achieve population health
49 management goals by:
50
51 a. Providing practice transformation support to primary care practitioners;
52
53 b. Providing comparative quality information on selected specialties; and
54

- c. Defining roles and responsibilities to achieve collaborative care management with provider partners.

H. Data Sharing with Practitioners and Providers

1. CalOptima Health shall share data with participating practitioners and providers to support population health management, including at a minimum:
 - a. Case management data for Members receiving case management services;
 - b. Utilization data to support follow-up and Member engagement; and
 - c. Quality performance data on agreed-upon measures.
 2. For each data type, the documented process shall identify:
 - a. Recipient(s);
 - b. Method of sharing; and
 - c. Frequency of sharing.
 3. CalOptima Health shall retain documentation demonstrating at least one instance of sharing for each data type.
 4. Data sharing shall be conducted in accordance with applicable privacy and security requirements.
- I. CalOptima Health shall evaluate the PHM Program using Key Performance Indicators (KPIs) and PHM Program evaluation in accordance with the following requirements:
1. Develop and use KPIs to continuously monitor and report on the implementation, operations, and effectiveness of the PHM Program.
 2. Conduct an analysis, at least annually, of the impact of its PHM Strategy that includes:
 - a. Quantitative results for at least four (4) measures, including clinical, cost/utilization, and member feedback/experience;
 - b. Comparison of results to a benchmark or goal; and
 - c. Interpretation of results, including qualitative analysis of how goals were met or not met.
 3. Using the results of the PHM impact analysis, CalOptima Health shall, at least annually, identify and act upon at least two opportunities for improvement.
 4. On an annual basis, CalOptima Health shall submit the PHM impact analysis to the QIHEC to share its findings and identify opportunities for future improvement efforts.
- J. When CalOptima Health delegates PHM Program activities to a Health Network or other delegated entity, oversight shall be conducted in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

1 **IV. ATTACHMENT(S)**

2
3 Not Applicable

4
5 **V. REFERENCE(S)**

- 6
7 A. CalOptima Health Comprehensive Wellness Program for Members under Twenty-One
8 B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
9 C. CalOptima Health Policy AA.1219a: Member Advisory Committee
10 D. CalOptima Health Policy AA.1219b: Provider Advisory Committee
11 E. CalOptima Health Policy CC.1500: Continuity of Care for Members Transitioning into CalOptima
12 Health
13 F. CalOptima Health Policy EE.1103: Provider Network Training
14 G. CalOptima Health Policy EE.1144: Memorandum of Understanding (MOU) Requirements for
15 CalOptima Health and Third-Party Entities
16 H. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
17 I. CalOptima Health Policy GG.1116: Pediatric Prevention Services
18 J. CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment
19 (EPSDT) Services
20 K. CalOptima Health Policy GG.1130: Community Based Adult Services (CBAS) Eligibility,
21 Authorization, Availability, and Care Coordination Processes
22 L. CalOptima Health Policy GG.1201: Health Education Programs
23 M. CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools
24 N. CalOptima Health Policy GG.1213: Community Health Worker Services
25 O. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
26 P. CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk
27 Assessments
28 Q. CalOptima Health Policy GG.1324: Seniors and Persons with Disabilities (SPD) Comprehensive
29 Case Management
30 R. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima
31 Health Services
32 S. CalOptima Health Policy GG.1330: Case Management – California Children’s Services
33 Program/Whole-Child Model
34 T. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery
35 U. CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and
36 Outreach
37 V. CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration
38 W. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services
39 (TCS)
40 X. CalOptima Health Policy GG.1532: Over and Under Utilization Monitoring
41 Y. CalOptima Health Policy GG.1613: Initial Health Appointment
42 Z. CalOptima Health Policy GG.1619: Delegation Oversight
43 AA. CalOptima Health Policy GG.1620: Quality Improvement Health Equity Committee (QIHEC)
44 BB. CalOptima Health Policy GG.1701: Maternity Services for Pregnant and Postpartum Members
45 CC. CalOptima Health Policy GG.1800: Authorization Process and Criteria for Admission to,
46 Continued Stay in, and Discharge from a Nursing Facility Level A (NF-A) and Level B (NF-B)
47 DD. CalOptima Health Policy GG.1803: Authorization Process and Criteria for Admission to,
48 Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric
49 EE. CalOptima Health Policy GG.1804: Admission to, Continued Stay in, and Discharge from Out-of-
50 Network Subacute Facility, Nursing Facility Level A (NF-A) and Level B (NF-B)
51 FF. CalOptima Health Policy GG.1808: Plan of Care, Long-Term Care
52 GG. CalOptima Health Policy GG.1830: In-Home Supportive Services (IHSS) Referral Coordination
53 Process

- 1 HH. CalOptima Health Policy GG.1832: Multipurpose Senior Services Program (MSSP) - MSSP
2 Identification, Referral, and Coordination of Care Process
3 II. CalOptima Health Policy GG.1900: Behavioral Health Services
4 JJ. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005: No Wrong Door for
5 Mental Health Services Policy
6 KK. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health
7 Management Program Guide (Supersedes APLs 17-012 and 17-013)
8 LL. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-030: Initial Health
9 Appointment (Supersedes APL 13-017 and Policy Letters 13-001 and 08-003)
10 MM. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004: Skilled Nursing
11 Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
12 (Supersedes APL 22-018)
13 NN. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs
14 Assessment and Population Health Management Strategy (Supersedes APL 19-011)
15 OO. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-009: Community
16 Advisory Committee
17 PP. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM)
18 Policy Guide, July 2025
19 QQ. Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)
20 RR. National Committee for Quality Assurance Standards and Guidelines
21

22 VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/18/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/29/2023	Department of Health Care Services (DHCS)	File and Use
08/15/2024	Department of Health Care Services (DHCS)	Approved as Submitted
11/12/2025	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

24 VII. BOARD ACTION(S)

Date	Meeting
06/01/2023	Regular Meeting of the CalOptima Health Board of Directors

26 VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	07/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	10/01/2023	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	07/01/2024	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised	11/01/2025	GG.1667	CalAIM Population Health Management Program	Medi-Cal
Revised		GG.1667	Population Health Management Program	Covered California Medi-Cal

IX. GLOSSARY

Term	Definition
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Care Manager	An individual identified as a single point of contact responsible for the provision of care management services for a member.
Case Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Children and Youth with Special Health Care Needs (CYSHCN)	Children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CYSHCN shall comply with the requirements of Title 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).
Complex Case Management (CCM)	The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medical Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship; 2. Emphasizes prevention of exacerbation and complications utilizing cost-effective and evidence-based practice guidelines and Member empowerment strategies such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving health.

Term	Definition
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The provision of Medically Necessary comprehensive and preventive health care services provided to Members less than twenty-one (21) years of age in accordance with requirements in 42 USC section 1396a(a)(43), section 1396d(a)(4)(B) and (r), and 42 CFR section 441.50 et seq., as required by W&I Code sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or behavioral health conditions.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
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.
Long Term Services and Supports (LTSS)	Services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services.
Medi-Cal Connect	An innovative statewide data solution to drive population health management (PHM), close gaps in services, and improve Member lives.
Member	<u>Covered California</u> : 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. <u>Medi-Cal</u> : 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.
Memorandum of Understanding (MOU)	An agreement between CalOptima Health and an external agency, which delineates responsibilities for coordinating care for Members.
National Committee for Quality Assurance (NCQA)	An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
Population Health Management (PHM)	A whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

Term	Definition
Population Health Management Committee (PHMC)	An advising committee that: 1. Provides overall direction for continuous process improvement and oversight of the Population Health Management (PHM) Program; 2. Ensures PHM activities are consistent with CalOptima Health's strategic goals and priorities; and 3. Monitors compliance with regulatory requirements.
Population Health Management Strategy (PHMS)	A comprehensive plan of action for addressing Member needs across the continuum of care, based on annual Population Needs Assessment (PNA) results, data driven risk stratification, predictive analysis, identified gaps in care, standardized assessment processes, and holistic care management interventions. CalOptima Health is required to include, at a minimum, a description of how it will: 1. Keep all Members healthy by focusing on wellness and prevention services; 2. Identify and manage Members with high and rising-risk; 3. a separate section on Members less than twenty-one (21) years of age; 4. Ensure effective transition planning, across delivery systems or settings, through care coordination and other means to minimize patient risk and ensure appropriate clinical outcomes for Member; and 5. Identify and mitigate Member access, experience, and clinical outcome disparities by race, ethnicity, and language to advance Health Equity.
Population Needs Assessment (PNA)	A process for: 1. Identifying Member health needs and Health Disparities; 2. Evaluating health education, Cultural and Linguistic (C&L), delivery system transformation and Quality Improvement (QI) activities and other available resources to address identified health concerns; and 3. Implementing targeted strategies for health education, C&L, and QI programs and services.
Primary Care	A basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to Specialty Care Provider focusing on specific needs.
Primary Care Practitioner/Physician (PCP)	A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
Prior Authorization	<u>Covered California</u>: 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). <u>Medi-Cal</u>: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

Term	Definition
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal</u>: 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.
Referral	The process of a Provider directing a Member to another Provider for care and or services. A referral may or may not need to be authorized and the Member may be redirected to another Provider from the original requested Provider.
Risk Stratification	A systematic process for identifying and predicting Member risk levels relating to health care needs, services, and coordination.
Risk Stratification and Segmentation (RSS)	The process of separating member populations into different risk groups and/or meaningful subsets using information collected through population assessments and other data sources. RSS results in the categorization of members with care needs at all levels and intensities.
Risk Tiering	The assigning of members to standard risk tiers (i.e., high, medium-rising, or low), with the goal of determining appropriate care management programs or specific services.
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. Also known as, Health Related Social Needs.
Social Needs	Non-clinical needs relating to institutions or functioning of humans in society to meet basic needs such as relationships, mental health status, or the needs for food and shelter.
Third Party Entities	Local health departments, local educational and governmental agencies, such as county behavioral health departments for specialty mental health care and SUD services, and other local programs and services.
Transitional Care Services	Services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).



Policy: GG.1201
Title: **Health Education Programs**
Department: Clinical Operations~~Medical Management~~
Section: Not Applicable~~Clinical Operations~~

CEO Approval: /s/

Effective Date: 03/01/1996

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

This policy establishes standards for health education programs available to Members.

II. POLICY

- A. CalOptima Health and its contracted Health Networks shall maintain a health education system that provides organized programs, services, and education to assist Members in improving their health and managing illness.
- B. CalOptima Health and its contracted Health Networks shall maintain appropriate health education standards, objectives, policies and procedures, and guidelines for its health education services, in accordance with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
- C. CalOptima Health and its contracted Health Networks shall implement evidence-based programs and services that aim to help Members set and achieve wellness goals. Such strategies must consider a Member's unique needs and focus on addressing health disparities.
- D. CalOptima Health and its contracted Health Networks delegated for health education shall provide services and resources to Members on topics that meet the needs of the diverse populations they serve, in a culturally and linguistically appropriate manner, in accordance with the Population Health Management (PHM) Strategy, informed by the Population Needs Assessment (PNA) process in accordance with CalOptima Health Policy GG.1667: CalAIM Population Health Management Program, and CalOptima Health's Cultural and Linguistic Services Guidelines, as set forth in CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- ~~E. CalOptima Health shall identify and implement comprehensive wellness initiatives and programs that address Member needs as identified in the PHM Strategy including wellness strategies and interventions that address Member needs as identified in the PNA.~~
- F.E. CalOptima Health and its contracted Health Networks shall contract with Network Providers that have expertise in the delivery of health education programs and services to the Member population.

III. PROCEDURE

A. Health Education Programs

1. CalOptima Health ~~and its contracted Health Networks~~ shall implement and maintain health education services, ~~in accordance with the Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS),~~ or any other managed care program requirements including:
 - a. Strategies, interventions, and evidence-based approaches that improve access to preventative health visits such as the Initial Health Appointment (IHA) which includes age-appropriate developmental screenings and services for Members less than twenty-one (21) years of age.
 - b. A process for training Network Providers, internal staff, and Health Networks on the provision of wellness and preventive services.
 2. CalOptima Health shall incorporate input from community advisory partners and Members into the development of strategies, interventions and programs that expand access and increase member penetration rates of health and wellness services.
 3. CalOptima Health shall designate a full-time Qualified Health Educator to provide administrative oversight, direction, and management of the health education system which ensures that:
 - a. Health education programs are available to Members on a regular basis and are provided at no ~~charge to Members~~ cost.
 - b. Health education programs and services are available to Members, including the availability of programs administered by contracted Health Networks delegated for health education.
 - i. Subject to the content and presentation standards set forth in this policy, CalOptima Health may coordinate health education programs with other organizations. ~~CalOptima Health~~
 - c. Health education may be presented in group or individual settings. Group settings shall be convenient for the type of presentation and target audience.
 - d. Health education classes shall be scheduled at various times and locations, offered either virtually or in person, to ensure that its wellness and prevention strategies and interventions the services are submitted to DHCS for review and approval in a form convenient to Members. Locations may include, but are not limited to, CalOptima Health offices, physician offices, clinics, senior centers, schools, community centers, places of worship, and method prescribed by DHCS public buildings that a Member or caregiver may easily access.
- 5.4. A Primary Care Provider (PCP) shall ~~provide~~ assess and identify appropriate health education in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.

1 ~~6.5.~~ A Practitioner shall provide health education as part of preventive and primary health care
2 visits.

3
4 a. A Practitioner shall provide anticipatory guidance at each health assessment visit for a
5 Member who is under twenty-one (21) years of age, in accordance with the American
6 Academy of Pediatrics (AAP) Bright Futures Guidelines and Periodicity Schedule.

7
8 ~~a.b.~~ A Practitioner shall ensure that health risk behaviors, health practices, and health education
9 needs related to health conditions are identified and that educational interventions, including
10 counseling and referral for health education services, are conducted, and documented in the
11 Member's Medical Record.

12
13 ~~b.c.~~ At subsequent visits, the Practitioner shall determine the progress toward mutually defined
14 objectives, reinforce the health education message, ~~support~~ and encourage progress
15 closure
16 of gaps in care.

17 ~~7. A Practitioner shall assess and identify Member health education needs and conduct educational~~
18 ~~intervention, in accordance with regulatory requirements.~~

19
20 ~~a.d.~~ If a Practitioner identifies a health education need during an assessment, the Practitioner
21 may:

22
23 i. Provide needed health education;

24
25 ii. Refer the Member or caregiver to CalOptima Health, the Member's affiliated Health
26 Network or appropriate health education ~~program; and/or~~ resources to meet health
27 education needs.

28
29 ~~iii. Refer Member to needed resources to meet health education needs.~~

30
31 ~~8. A Practitioner shall provide health education and anticipatory guidance at each health~~
32 ~~assessment visit for a Member who is under twenty one (21) years of age and their parents or~~
33 ~~guardians, in accordance with the American Academy of Pediatrics (AAP) Bright Futures~~
34 ~~Guidelines and Periodicity Schedule.~~

35
36 ~~i.b.~~ Each Practitioner's office shall have access to educational materials and resources on relevant
37 health topics, including, but not limited to prevention and health management.

38
39 ~~j.c.~~ CalOptima Health shall provide resources, educational materials, and other program resources
40 to assist a Practitioner in providing effective health education services to a Member.

41
42 ~~k.d.~~ A Health Educator shall be educated and trained in the development and presentation, or
43 instruction of health education information. The Health Educator shall be capable of
44 developing, presenting, and instructing Members on health education topics.

45
46 ~~12. CalOptima Health shall ensure that written health education presentations and materials are age-~~
47 ~~appropriate, no higher than a sixth (6th) grade reading level, and available in Threshold~~
48 ~~Languages, in a manner that is culturally and linguistically appropriate for the intended~~
49 ~~audience, in accordance with CalOptima Health Policy GG.1206: Readability and Suitability of~~
50 ~~Written Health Education Materials.~~

~~13.1. CalOptima Health shall ensure that health education materials for Members are accompanied by a notice of non-discrimination, written in at least a twelve (12) point font.~~

~~14. Health education may be presented in Group Settings or using Individual Contact. Group Settings shall be convenient for the type of presentation and target audience. Locations may include, but are not limited to, CalOptima Health offices, physician offices or clinics, senior centers, schools and community centers, places of worship, and public buildings that a Member may easily access.~~

~~a. Classes shall be scheduled at various times and locations to ensure that the services are convenient to Members.~~

~~e.e.~~ CalOptima Health shall promote health education services and encourage Member attendance or participation ~~in health education programs~~ by notifying Members of scheduled events through the PCP, CalOptima Health website, and communication via U.S. Mail and by other means, as appropriate.

B. Referral Process

1. CalOptima Health shall inform a Member ~~about participation in~~ they may self-refer for health education services without a referral from a Practitioner and can opt out of a program or service at any ~~given~~ time. CalOptima Health shall also inform a Member that they may enroll or obtain information on classes by contacting the Customer Service Department.
2. A Practitioner may refer a Member directly to CalOptima Health or the Member's affiliated Health Network for health education services.
3. Upon receipt of a ~~Member~~ referral through a Practitioner or Member self-referral, CalOptima Health shall within fourteen (14) calendar days ~~after receipt of the referral:~~
 - a. Contact the Member to provide the requested health education information or schedule the Member as appropriate for health education intervention;
 - b. Document the referral interactions; and
 - c. As needed, follow-up with a Member who does not keep a scheduled appointment.
4. CalOptima Health shall inform the referring Practitioner of any services and programs provided for collaboration and inclusion in the Member's Medical Record.

C. Required Program Topics

- ~~1. CalOptima Health shall make health education programs available to Members on a regular basis.~~
- ~~2. Subject to the content and presentation standards set forth in this policy, CalOptima Health may coordinate health education programs with other organizations.~~
- 3.1. CalOptima Health shall offer health education programs covering health conditions and topics which ~~shall~~ include, but are not ~~be~~ limited to:

- 1 a. Age-specific anticipatory guidance according to the American Academy of Pediatrics
2 (AAP) and the United States Preventative Services Task Force;
3
4 b. Educational interventions designed to assist Members to effectively use the managed health
5 care system, preventive and primary healthcare services, health education services; and
6 appropriately use complementary and alternative care;
7
8 c. Educational interventions designed to assist Members in modifying personal health
9 behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes.
10 Services must include comprehensive wellness and prevention programs that offer
11 evidence-based self-management tools with information on at least the following areas:
12
13 i. Avoiding alcohol (at-risk drinking), and drug use;
14
15 ii. Encouraging physical activity;
16
17 iii. Healthy eating;
18
19 iv. Healthy weight (BMI) maintenance;
20
21 v. Identifying depressive symptoms;
22
23 vi. Managing stress; and
24
25 vii. Smoking and tobacco use cessation.
26
27 d. Evidence-based disease management programs, which shall incorporate health education
28 interventions, identify members for engagement, and seek to close care gaps with a focus on
29 improving equity and reducing health disparities. Programs must address the following
30 conditions at a minimum:
31
32 i. Asthma;
33
34 ii. Cardiovascular disease;
35
36 iii. Depression; and
37
38 iv. Diabetes.
39
40 ~~4.1. CalOptima Health shall provide Members with access to interactive self management tools in~~
41 ~~accordance with CalOptima Health Policy GG.1211: Health Appraisals and Self Management~~
42 ~~tools.~~
43
44 ~~5.2.~~ Programs shall include a written outline that delineates the following:
45
46 a. Goals of the educational session;
47
48 b. Measurable outcome objectives for the Member;
49
50 c. Outline of topics covered in presentation;
51
52 d. List of teaching methods used, including interactive approaches when possible; and

e. An evaluation tool.

6.3. Appropriate materials to enhance instruction ~~included in Threshold Languages, or other languages as appropriate for the population being served~~, may include, but are not limited to, the following:

- a. Printed posters, ~~pamphlets factsheets~~, self-learning ~~modules in Threshold Languages, or other languages, as appropriate for the population being served~~ booklets;
- b. Videos or digital platforms;
- c. Interactive telephonic programs;
- d. ~~Lectures~~ Presentations; and
- e. Pediatric-specific materials such as coloring books and ~~puppets~~ portioned plates.

4. CalOptima Health shall ensure that written health education presentations and materials are age-appropriate, no higher than a sixth (6th) grade reading level, and available in Threshold Languages, in a manner that is culturally and linguistically appropriate for the intended audience, in accordance with CalOptima Health Policy GG.1206: Readability and Suitability of Written Health Education Materials

5. CalOptima Health shall ensure that health education materials for Members are accompanied by a notice of non-discrimination, written in at least a twelve (12)-point font.

6. CalOptima Health shall provide Members with access to interactive self-management tools in accordance with CalOptima Health Policy GG.1211: Health Appraisals and Self-Management tools.

D. Monitoring and Reporting Requirements

1. On a quarterly basis, the health education program shall ~~monitor and~~ report to the ~~Population Quality Improvement Health Management Equity~~ Committee (~~PHMCQIHEC~~) the availability of health education programs and services for Members, in accordance with the PHM Strategy and Workplan. The report shall include:
 - a. Aggregated trends of received referrals;
 - b. Source of received referrals;
 - c. Referrals by condition or topic;
 - d. Barriers; and
 - e. Opportunities for improving health education services.
2. On a semi-annual basis, contracted Health Networks delegated for health education services shall submit, on January 31 and July 31, reports informing CalOptima Health of program and service availability for Members. Reports shall include aggregate information on services accessed by Members, including self-learning modules and/or materials. The ~~health education program~~ Qualified Health Educator will evaluate and monitor the reports and ensure that

services are delivered in a culturally and linguistically appropriate manner, ~~as well as~~ in accordance with the standards set forth by regulatory guidance.

3. Contracted Health Network delegated for health education services identified with elements out of compliance with regulatory standards for delivering health education programs and/or frequency of reporting requirements shall be subject to a Focused Review and may require a Corrective Action Plan (CAP) if the issue remains unresolved, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Contract for Health Care Services
- B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
- D. CalOptima Health PACE Program Agreement
- E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
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- G. CalOptima Health Policy GG.1206: Readability and Suitability of Written Health Education Materials
- H. CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools
- I. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
- J. CalOptima Health Policy HH.2002: Sanctions
- K. CalOptima Health Policy HH.2005: Corrective Action Plan
- L. Health Education Program Content Requirements
- ~~M. Department of Health Care Services (DHCS) Policy Letter (PL) 02-004: Health Education~~
- ~~N.M.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Policy Guide (Supersedes APLs 17-012 and 17-013)
- ~~O.N.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
- ~~P.O.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-021: Population Needs Assessment and Population Health Management Strategy (Supersedes APL 19-011)
- ~~Q.P.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 25-005: Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, Alternative Formats (Supersedes APL 21-004)
- ~~R.Q.~~ Department of Health Care Services (DHCS) CalAIM Population Health Management (PHM) Policy Guide, ~~July 2025~~ January 2026
- ~~S.R.~~ 2025 National Committee of Quality Assurance (NCQA) Health Plan Standards
- ~~T.S.~~ American Academy of Pediatrics (AAP) Bright Futures Guidelines.
- ~~U.T.~~ United States Preventative Services Task Force
- ~~V.U.~~ Title, 42, Code of Federal Regulations, § 438.236

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/29/2010	Department of Health Care Services (DHCS)	Approved as Submitted
11/25/2013	Department of Health Care Services (DHCS)	Approved as Submitted

Date	Regulatory Agency	Response
06/11/2015	Department of Health Care Services (DHCS)	Approved as Submitted
12/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
04/23/2020	Department of Health Care Services (DHCS)	Approved as Submitted
12/13/2021	Department of Health Care Services (DHCS)	Approved as Submitted
06/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/21/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/02/2023	Department of Health Care Services (DHCS)	File and Use
10/31/2024	Department of Health Care Services (DHCS)	File and Use
04/23/2025	Department of Health Care Services (DHCS)	File and Use
09/17/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1996	GG.1201	Health Education Programs	Medi-Cal
Revised	04/01/1998	GG.1201	Health Education Programs	Medi-Cal
Revised	05/01/1999	GG.1201	Health Education Programs	Medi-Cal
Revised	08/01/2002	GG.1201	Health Education Programs	Medi-Cal
Revised	01/01/2007	GG.1201	Health Education Programs	Medi-Cal
Revised	05/01/2007	GG.1201	Health Education Programs	Medi-Cal
Revised	01/01/2010	GG.1201	Health Education Programs	Medi-Cal
Revised	11/01/2015	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2016	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2017	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	09/01/2018	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2018	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	09/01/2019	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2020	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2021	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	07/01/2023	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	10/01/2023	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	09/01/2025	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
<u>Revised</u>		<u>GG.1201</u>	<u>Health Education Programs</u>	<u>Medi-Cal</u> <u>OneCare</u> <u>PACE</u>

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
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 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.
Focused Review	An audit that specifically targets areas of potential deficiency.
Group Setting	A class or other group presentation that is designed specifically for Health Education purposes.
Health Educator	A person qualified by education, training, or experience to develop, coordinate, or present instruction to Members.
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.
Individual Contact	One-on-one interactive learning for a specific educational purpose utilizing materials or presentations.
Medical Record	<u>Covered California: 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.</u> <u>Medi-Cal:</u> 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. <u>OneCare:</u> A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. <u>PACE:</u> Written documentary evidence of treatments rendered to plan Members.
Member	An individual enrolled in a CalOptima Health program.

Term	Definition
Network Provider	<u>Covered California: Any provider as defined in HSC § 1345(i) located inside or outside of the Network Service Area of a designated network who meets all of the following criteria listed in Title 28 CCR § 1300.67.2.2(b)(10).</u> <u>Medi-Cal: Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.</u>
Population Health Management Committee (PHMC)	An advising committee that: 1. Provides overall direction for continuous process improvement and oversight of the Population Health Management (PHM) Program; 1. Ensures PHM activities are consistent with CalOptima Health's strategic goals and priorities; and 2.1. Monitors compliance with regulatory requirements.
Population Health Management Strategy (PHM Strategy)	The PHM Strategy is a comprehensive, accountable plan of action for addressing Member needs and preferences across the continuum of care.
Population Needs Assessment (PNA)	A multi-year process during which CalOptima Health will identify and respond to the needs of its Members and the communities it serves by participating in the Community Health Assessment (CHA) of Local Health Departments (LHDs) in its Service Area. The findings of the PNA/CHA collaboration will inform CalOptima Health's annual PHM Strategy.
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.
Primary Care Practitioner/Physician (PCP)	A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
Qualified Health Educator	A qualified health educator is defined as a health educator with one (1) of the following qualifications: 1. Master of Public Health (MPH) degree with a specialization in health education or health promotion, from a program of study accredited by the Council on Education for Public Health, sanctioned by the American Public Health Association; or 2. MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.

Term	Definition
<u>Quality Improvement Health Equity Committee (QIHEC)</u>	<u>An advising committee that:</u> <u>1. Provides overall direction for continuous process improvement and oversight of the Population Health Management (PHM) Program;</u> <u>2. Ensures activities are consistent with CalOptima Health's strategic goals and priorities; and</u> <u>Monitors compliance with regulatory requirements.</u>
Threshold Languages	<u>Covered California & Medi-Cal:</u> The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS. <u>OneCare:</u> A threshold language is defined by CMS as the native language of a group who comprises five percent (5%) or more of the people served by the CMS Program.

Policy: GG.1201
Title: **Health Education Programs**
Department: Clinical Operations
Section: Not Applicable

CEO Approval: /s/

Effective Date: 03/01/1996
Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☒ PACE

I. PURPOSE

This policy establishes standards for health education programs available to Members.

II. POLICY

- A. CalOptima Health and its contracted Health Networks shall maintain a health education system that provides organized programs, services, and education to assist Members in improving their health and managing illness.
- B. CalOptima Health and its contracted Health Networks shall maintain appropriate health education standards, objectives, policies and procedures, and guidelines for its health education services, in accordance with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
- C. CalOptima Health and its contracted Health Networks shall implement evidence-based programs and services that aim to help Members set and achieve wellness goals. Such strategies must consider a Member's unique needs and focus on addressing health disparities.
- D. CalOptima Health and its contracted Health Networks delegated for health education shall provide services and resources to Members on topics that meet the needs of the diverse populations they serve, in a culturally and linguistically appropriate manner, in accordance with the Population Health Management (PHM) Strategy, informed by the Population Needs Assessment (PNA) process in accordance with CalOptima Health Policy GG.1667: CalAIM Population Health Management Program, and CalOptima Health's Cultural and Linguistic Services Guidelines, as set forth in CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- E. CalOptima Health and its contracted Health Networks shall contract with Network Providers that have expertise in the delivery of health education programs and services to the Member population.

III. PROCEDURE

- A. Health Education Programs

1. CalOptima Health and its contracted Health Networks shall implement and maintain health education services, or any other managed care program requirements including:
 - a. Strategies, interventions, and evidence-based approaches that improve access to preventative health visits such as the Initial Health Appointment (IHA) which includes age-appropriate developmental screenings and services for Members less than twenty-one (21) years of age.
 - b. A process for training Network Providers, internal staff, and Health Networks on the provision of wellness and preventive services.
2. CalOptima Health shall incorporate input from community advisory partners and Members into the development of strategies, interventions and programs that expand access and increase member penetration rates of health and wellness services.
3. CalOptima Health shall designate a full-time Qualified Health Educator to provide administrative oversight, direction, and management of the health education system which ensures that:
 - a. Health education programs are available to Members on a regular basis and are provided at no cost.
 - b. Health education programs and services are available to Members, including the availability of programs administered by contracted Health Networks delegated for health education.
 - i. Subject to the content and presentation standards set forth in this policy, CalOptima Health may coordinate health education programs with other organizations.
 - c. Health education may be presented in group or individual settings. Group settings shall be convenient for the type of presentation and target audience.
 - d. Health education classes shall be scheduled at various times and locations, offered either virtually or in person, to ensure that the services are convenient to Members. Locations may include, but are not limited to, CalOptima Health offices, physician offices, clinics, senior centers, schools, community centers, places of worship, and public buildings that a Member or caregiver may easily access.
4. A Primary Care Provider (PCP) shall assess and identify appropriate health education in accordance with CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities.
5. A Practitioner shall provide health education as part of preventive and primary health care visits.
 - a. A Practitioner shall provide anticipatory guidance at each health assessment visit for a Member who is under twenty-one (21) years of age, in accordance with the American Academy of Pediatrics (AAP) Bright Futures Guidelines and Periodicity Schedule.
 - b. A Practitioner shall ensure that health risk behaviors, health practices, and health education needs related to health conditions are identified and that educational interventions, including counseling and referral for health education services, are conducted, and documented in the Member's Medical Record.

- c. At subsequent visits, the Practitioner shall determine the progress toward mutually defined objectives, reinforce the health education message, and encourage closure of gaps in care.
- d. If a Practitioner identifies a health education need during an assessment, the Practitioner may:
 - i. Provide needed health education;
 - ii. Refer the Member or caregiver to CalOptima Health, the Member's affiliated Health Network or appropriate health education resources to meet health education needs.
- b. Each Practitioner's office shall have access to educational materials and resources on relevant health topics, including, but not limited to prevention and health management.
- c. CalOptima Health shall provide resources, educational materials, and other program resources to assist a Practitioner in providing effective health education services to a Member.
- d. A Health Educator shall be educated and trained in the development and presentation, or instruction of health education information. The Health Educator shall be capable of developing, presenting, and instructing Members on health education topics.
- e. CalOptima Health shall promote health education services and encourage Member attendance or participation by notifying Members of scheduled events through the PCP, CalOptima Health website, and communication via U.S. Mail and by other means, as appropriate.

B. Referral Process

1. CalOptima Health shall inform a Member they may self-refer for health education services without a referral from a Practitioner and can opt out of a program or service at any time. CalOptima Health shall also inform a Member that they may enroll or obtain information on classes by contacting the Customer Service Department.
2. A Practitioner may refer a Member directly to CalOptima Health or the Member's affiliated Health Network for health education services.
3. Upon receipt of a referral through a Practitioner or Member self-referral, CalOptima Health shall within fourteen (14) calendar days :
 - a. Contact the Member to provide the requested health education information or schedule the Member as appropriate for health education intervention;
 - b. Document the referral interactions; and
 - c. As needed, follow-up with a Member who does not keep a scheduled appointment.
4. CalOptima Health shall inform the referring Practitioner of any services and programs provided for collaboration and inclusion in the Member's Medical Record.

C. Required Program Topics

1. CalOptima Health shall offer health education programs covering health conditions and topics which include, but are not limited to:
 - a. Age-specific anticipatory guidance according to the American Academy of Pediatrics (AAP) and the United States Preventative Services Task Force;
 - b. Educational interventions designed to assist Members to effectively use the managed health care system, preventive and primary healthcare services, health education services; and appropriately use complementary and alternative care;
 - c. Educational interventions designed to assist Members in modifying personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes. Services must include comprehensive wellness and prevention programs that offer evidence-based self-management tools with information on at least the following areas:
 - i. Avoiding alcohol (at-risk drinking), and drug use;
 - ii. Encouraging physical activity;
 - iii. Healthy eating;
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 - v. Identifying depressive symptoms;
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 - d. Evidence-based disease management programs shall incorporate health education interventions, identify members for engagement, and seek to close care gaps with a focus on improving equity and reducing health disparities. Programs must address the following conditions at a minimum:
 - i. Asthma;
 - ii. Cardiovascular disease;
 - iii. Depression; and
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2. Programs shall include a written outline that delineates the following:
 - a. Goals of the educational session;
 - b. Measurable outcome objectives for the Member;
 - c. Outline of topics covered in presentation;
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3. Appropriate materials to enhance instruction included in Threshold Languages, or other languages as appropriate for the population being served, may include, but are not limited to, the following:
 - a. Printed posters, factsheets, self-learning booklets ;
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 - d. Presentations; and
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D. Monitoring and Reporting Requirements

1. On a quarterly basis, the health education program shall report to the Quality Improvement Health Equity Committee (QIHEC) the availability of health education programs and services for Members, in accordance with the PHM Strategy and Workplan. The report shall include:
 - a. Aggregated trends of received referrals;
 - b. Source of received referrals;
 - c. Referrals by condition or topic;
 - d. Barriers; and
 - e. Opportunities for improving health education services.
2. On a semi-annual basis, contracted Health Networks delegated for health education services shall submit, on January 31 and July 31, reports informing CalOptima Health of program and service availability for Members. Reports shall include aggregate information on services accessed by Members, including self-learning modules and/or materials. The Qualified Health Educator will evaluate and monitor the reports and ensure that services are delivered in a culturally and linguistically appropriate manner, in accordance with the standards set forth by regulatory guidance.

3. Contracted Health Network delegated for health education services identified with elements out of compliance with regulatory standards for delivering health education programs and/or frequency of reporting requirements shall be subject to a Focused Review and may require a Corrective Action Plan (CAP) if the issue remains unresolved, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan, and HH.2002: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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- B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
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- G. CalOptima Health Policy GG.1206: Readability and Suitability of Written Health Education Materials
- H. CalOptima Health Policy GG.1211: Health Appraisals and Self-Management Tools
- I. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
- J. CalOptima Health Policy HH.2002: Sanctions
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- Q. Department of Health Care Services (DHCS) CalAIM Population Health Management (PHM) Policy Guide, January 2026
- R. 2025 National Committee of Quality Assurance (NCQA) Health Plan Standards
- S. American Academy of Pediatrics (AAP) Bright Futures Guidelines.
- T. United States Preventative Services Task Force
- U. Title, 42, Code of Federal Regulations, § 438.236

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/29/2010	Department of Health Care Services (DHCS)	Approved as Submitted
11/25/2013	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2015	Department of Health Care Services (DHCS)	Approved as Submitted
12/11/2019	Department of Health Care Services (DHCS)	Approved as Submitted
04/23/2020	Department of Health Care Services (DHCS)	Approved as Submitted
12/13/2021	Department of Health Care Services (DHCS)	Approved as Submitted

Date	Regulatory Agency	Response
06/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/21/2023	Department of Health Care Services (DHCS)	Approved as Submitted
11/02/2023	Department of Health Care Services (DHCS)	File and Use
10/31/2024	Department of Health Care Services (DHCS)	File and Use
04/23/2025	Department of Health Care Services (DHCS)	File and Use
09/17/2025	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1996	GG.1201	Health Education Programs	Medi-Cal
Revised	04/01/1998	GG.1201	Health Education Programs	Medi-Cal
Revised	05/01/1999	GG.1201	Health Education Programs	Medi-Cal
Revised	08/01/2002	GG.1201	Health Education Programs	Medi-Cal
Revised	01/01/2007	GG.1201	Health Education Programs	Medi-Cal
Revised	05/01/2007	GG.1201	Health Education Programs	Medi-Cal
Revised	01/01/2010	GG.1201	Health Education Programs	Medi-Cal
Revised	11/01/2015	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	11/01/2016	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2017	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	09/01/2018	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	12/01/2018	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	09/01/2019	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2020	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2021	GG.1201	Health Education Programs	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	07/01/2023	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	10/01/2023	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised	09/01/2025	GG.1201	Health Education Programs	Medi-Cal OneCare PACE
Revised		GG.1201	Health Education Programs	Medi-Cal OneCare PACE

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1 IX. GLOSSARY
2

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
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 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.
Focused Review	An audit that specifically targets areas of potential deficiency.
Group Setting	A class or other group presentation that is designed specifically for Health Education purposes.
Health Educator	A person qualified by education, training, or experience to develop, coordinate, or present instruction to Members.
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.
Individual Contact	One-on-one interactive learning for a specific educational purpose utilizing materials or presentations.
Medical Record	<u>Covered California</u>: 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. <u>Medi-Cal</u>: 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. <u>OneCare</u>: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. <u>PACE</u>: Written documentary evidence of treatments rendered to plan Members.
Member	An individual enrolled in a CalOptima Health program.

Term	Definition
Network Provider	<u>Covered California</u>: Any provider as defined in HSC § 1345(i) located inside or outside of the Network Service Area of a designated network who meets all of the following criteria listed in Title 28 CCR § 1300.67.2.2(b)(10). <u>Medi-Cal</u>: Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
	1.
Population Health Management Strategy (PHM Strategy)	The PHM Strategy is a comprehensive, accountable plan of action for addressing Member needs and preferences across the continuum of care.
Population Needs Assessment (PNA)	A multi-year process during which CalOptima Health will identify and respond to the needs of its Members and the communities it serves by participating in the Community Health Assessment (CHA) of Local Health Departments (LHDs) in its Service Area. The findings of the PNA/CHA collaboration will inform CalOptima Health's annual PHM Strategy.
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.
Primary Care Practitioner/Physician (PCP)	A Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Seniors and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.
Qualified Health Educator	A qualified health educator is defined as a health educator : 1. Master of Public Health (MPH) degree with a specialization in health education or health promotion, from a program of study accredited by the Council on Education for Public Health, sanctioned by the American Public Health Association; or 2.
Quality Improvement Health Equity Committee (QIHEC)	An advising committee that: 1. Provides overall direction for continuous process improvement and oversight of the Population Health Management (PHM) Program; 2. Ensures activities are consistent with CalOptima Health's strategic goals and priorities; and Monitors compliance with regulatory requirements.

Term	Definition
Threshold Languages	<u>Covered California & Medi-Cal</u>: The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS. <u>OneCare</u>: A threshold language is defined by CMS as the native language of a group who comprises five percent (5%) or more of the people served by the CMS Program.

1

For 20261001 BOD Review Only

Policy: GG.1708
 Title: **Disease Management Program**
 Department: Case Management
 Section: Not Applicable

CEO Approval: /s/

Effective Date: TBD
 Revised Date: N/A

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

This policy applies to CalOptima Health and all Delegated Health Networks responsible for implementing Disease Management (DM) Program activities, including Member self-management, services delivered by the Provider at the point of care, and interactive outreach methods delivered by CalOptima Health and Delegated Health Networks. This policy defines the structure, eligibility criteria, operational standards, and evaluation framework for CalOptima Health's Disease Management DM Program.

II. POLICY

- A. The DM Program is part of CalOptima Health's Care Management continuum and is delivered through a structured, proactive system of care designed to improve the health of Members with chronic conditions.
- B. CalOptima Health and its Health Networks shall implement a DM Program that identifies Members with specific Chronic Health Conditions using data-driven methods, delivers evidence-based education, condition Monitoring, and Care Coordination.
- C. The CalOptima Health DM Program provides evidence-based, condition-specific interventions to Members with Chronic Health Conditions to:
 1. Support the Provider-patient relationship; DM Program activities shall not interfere with, replace, or supersede a Provider's counseling, treatment recommendations, or clinical decision-making with a Member
 2. Improve clinical outcomes;
 3. Reduce preventable utilization of inpatient and emergency care;
 4. Increase self-management capacity;
 5. Close preventive care and quality gaps; and
 6. Prevent progression to higher levels of clinical risk and complexity.

1
2 D. The DM Program shall address, but are not limited to, the following conditions:
3

- 4 1. Diabetes (Type 1 and Type 2);
5
6 2. Cardiovascular Disease, including Congestive Heart Failure;
7
8 3. Asthma; and
9
10 4. Depression.
11

12 E. The DM Program content should be consistent and supportive of the condition-specific clinical
13 practice guidelines per CalOptima Health Policy GG.1204: Clinical Practice Guidelines.
14

15 F. The DM Program shall incorporate health equity principles in program design, outreach, and
16 intervention delivery. CalOptima Health shall monitor DM Program participation, engagement, and
17 outcomes across Member subpopulations, with specific attention to health disparities related to race,
18 ethnicity, language, and social determinants of health.
19

20 G. As part of the Population Health Management (PHM) Strategy, the DM Program shall provide
21 quarterly updates and an annual evaluation to the Quality Improvement and Health Equity
22 Committee or one of its subcommittees in accordance with CalOptima Health Policy GG.1620:
23 Quality Improvement Health Equity Committee (QIHEC).
24

25 H. The DM Program shall align with the Department of Health Care Services (DHCS) requirements
26 and the following elements from the National Committee for Quality Assurance (NCQA)
27 Population Health Management (PHM) standards:
28

29 1. Population Identification
30

- 31 a. Members with chronic conditions are identified for engagement through data-driven
32 methods, including claims, laboratory values, pharmacy data, health appraisals, and
33 Provider referrals, using condition-specific inclusion and exclusion criteria.
34

35 2. Data Integration
36

- 37 a. Multiple data sources, including but not limited to claims, encounters, laboratory results,
38 and pharmacy data are integrated to stratify Members and inform outreach and intervention
39 selection.
40

41 3. Population Stratification
42

- 43 a. Members are segmented by risk tier, with outreach frequency and intervention intensity
44 corresponding to stratification level.
45

46 4. Interventions
47

- 48 a. Condition-specific interventions aligned with evidence-based clinical guidelines are
49 delivered to support self-management, Care Coordination, and condition Monitoring.
50 Interventions may include, but not be limited to, access to self-management support tools,
51 engagement with healthcare Providers at the point of care, and/or interactive contact
52 methods.

- i. CalOptima Health shall make available to Members self-management tools that provide condition-specific education and self-management support across required topic areas.
- ii. Self-management tools shall meet NCQA PHM standards for self-management tool functionality and content, shall be accessible to Members in a culturally and linguistically appropriate manner in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic Services and use plain language in accordance with CalOptima Health Policy GG.1206: Readability and Suitability of Member Materials.

5. Care Coordination

- a. The DM Program operates as part of CalOptima Health's Care Management continuum, which includes basic Care Management, Care Coordination, Complex Case Management (CCM), Enhanced Care Management (ECM) and Transitional Care Services (TCS) with defined roles and accountability standards for program delivery and coordination across care settings.
- b. Members enrolled in DM services may be stepped up to a higher level of intervention or transitional care when clinical complexity, acute utilization, or other factors indicate a need.
- c. Members transitioning out of a higher level of intervention or transitional care may be stepped down to DM services to support continued self-management.
- d. Transitions between programs shall include a warm handoff and documented coordination to ensure continuity of the Member's care plan.

6. Measurement and Quality Improvement

- a. Program outcomes are evaluated on an ongoing basis across clinical, utilization, health equity, and Member engagement metrics, with results used to inform continuous quality improvement.

7. Population Needs Assessment and Local Planning

- a. Program design and condition prioritization are informed by the health needs of CalOptima Health's annual Member population assessment and Local Planning requirements.

III. PROCEDURE

A. CalOptima Health and its Health Networks shall identify Members for DM services using:

1. Claims, pharmacy, health appraisals, and lab data;
2. Risk stratification outputs (including Medi-Cal Connect risk tiers);
3. Healthcare Effectiveness Data and Information Set (HEDIS) gap reports; and
4. Provider, Case Management, or Member self-referrals.

1 B. Members shall be stratified into risk tiers, in accordance with CalOptima Health Policy GG.1667:
2 CalAIM Population Health Management Program, to determine outreach priority and intensity of
3 interventions.
4

5 C. Member Eligibility and Outreach
6

7 1. Members eligible for DM services shall meet all of the following criteria:
8

- 9 a. Have a confirmed diagnosis of a qualifying condition (diabetes, asthma, cardiovascular
10 disease, depression);
11
12 b. Meet defined clinical/utilization thresholds based on condition-specific clinical practice
13 guidelines; and
14
15 c. Not currently enrolled in Complex Case Management, ECM, Long Term Care,
16 hospice/palliative care, or TCS.
17

18 2. DM Services Outreach
19

- 20 a. Outreach timeframes and methods shall be defined in the DM Program operational
21 guidelines and will be based upon condition-specific urgency and risk level.
22
23 i. Outreach may include, but not be limited to, the following interactive contact methods:
24 telephonic outreach, text message, in-person contact (individual or group), mailed
25 information, secure electronic messaging, live chat, video conference, interactive web-
26 based communication, or interactive voice response (IVR) call.
27
28 b. Outreach shall be conducted in a manner that is culturally and linguistically appropriate for
29 the member, in accordance with CalOptima Health Policy DD.2002: Cultural and Linguistic
30 Services, including providing meaningful access for Members with Limited English
31 Proficiency through qualified interpreter services and translated materials in threshold
32 languages, and providing auxiliary aids and services, alternative formats, and other
33 reasonable accommodations for Members with disabilities.
34
35 c. Outreach with interactive contact for Members participating in DM shall include the
36 following:
37
38 i. Protection and/or verification of Member's identity in compliance with Health
39 Insurance Portability and Accountability Act (HIPAA).
40
41 ii. Information about the program, including:
42
43 a) How the Member became eligible to participate in the DM Program.
44
45 b) How the Member can access and use available DM services.
46
47 c) How to opt in or out of the DM services.
48
49 1) Members who decline DM services shall have their preferences documented in
50 the Care Management system.
51

- 1 2) Members who opt out of DM services remain eligible for re-enrollment and
2 shall be re-offered services under the following circumstances:
3
4 a. A significant change in clinical status or utilization patterns is identified;
5
6 b. A Provider or care team member submits a new referral;
7
8 c. At least six (6) months have elapsed since the Member's initial declination
9
- 10 iii. Condition-specific assessments shall be conducted for high-risk members, including,
11 but not limited to:
12
13 a) Current clinical status;
14
15 b) Recent healthcare utilization;
16
17 c) Medication review and adherence barriers;
18
19 d) Condition-specific knowledge and self-management capacity;
20
21 e) Behavioral health and social determinants of health needs.
22
- 23 1) Members with identified behavioral health needs during DM assessment shall
24 be referred to appropriate services in accordance with CalOptima Health
25 Policies MA.7020: Behavioral Health Services and GG.1900: Behavioral
26 Health Services.
27
- 28 iv. Care Coordination and health management support, including but not limited to:
29
30 a) Education about appropriate clinical goals;
31
32 b) Personalized self-management goals;
33
34 c) Interventions and support to address barriers;
35
36 d) Health education and reinforcement tools;
37
38 e) Appropriate referrals to Primary Care Provider (PCP) and/or specialists based on
39 Member needs, including support to schedule appointments and transportation.
40
- 41 d. Documentation shall be made in the Care Management system or Member record and
42 include:
43
44 i. Outreach attempts and modality;
45
46 ii. Initial and follow-up outreach and/or assessments;
47
48 iii. Health management and Care Coordination interventions, including referrals and
49 coordination with other Providers; and
50
51 iv. Member consent or declination of services.
52

- e. CalOptima Health and its Health Networks shall ensure that Member notification materials and workflows for interactive contact are documented and available as evidence for NCQA accreditation and/or regulatory and compliance audits.

D. Health Networks

1. Delegated Health Networks shall implement, monitor and report on DM services in a method prescribed by CalOptima Health in the DM operational guide. CalOptima Health shall monitor a Health Network's DM services, in accordance with this Policy and CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
B. CalOptima Health Policy GG.1204: Clinical Practice Guidelines
C. CalOptima Health Policy GG.1206: Readability and Suitability of Member Materials
D. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
E. CalOptima Health Policy GG.1619: Delegation Oversight
F. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
G. CalOptima Health Policy GG.1900: Behavioral Health Services
H. CalOptima Health Policy MA.7020: Behavioral Health Services
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024: Population Health Management Policy Guide
J. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, January 2026

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1708	Disease Management Program	Covered California Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Care Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Complex Care/Case Management (CCM)	<u>Medi-Cal</u> : An approach to care management that meets differing needs of high- and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements. <u>OneCare</u> : The systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis, that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and 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.
Disease Management	A multi-disciplinary and continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions and that: 1. Supports the physician/Member relationship. 2. Emphasizes preventing exacerbations and complications using cost-effective, evidence-based practice guidelines and Member empowerment strategies, such as self-management; and 3. Continuously evaluates clinical, humanistic, and economic outcomes to improve health.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

Term	Definition
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 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.
Medi-Cal Connect	A data backed platform that collects and links Medi-Cal beneficiary information from disparate sources and performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multi-party data access and use in accordance with State and federal laws, regulations, and policies.
Member	A individual enrolled in a CalOptima Health program.
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.
National Committee for Quality Assurance (NCQA)	<u>Covered California</u>: The National Committee for Quality Assurance, a nonprofit accreditation agency. <u>Medi-Cal</u>: 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. <u>OneCare</u>: An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.
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.

Term	Definition
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.
Population Health Management (PHM)	A whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.
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
Transitional Care Services (TCS)	Services provided to all members transferring from one institutional care setting or level of care to another institution or lower level of care (including home settings).



Policy: GG.1701
Title: ~~CalOptima Health Perinatal Support Maternity Services (PSS) Program for Pregnant and Postpartum Members~~
Department: ~~Medical Case~~ Management
Section: ~~Case Management~~ Not Applicable

CEO Approval: /s/

Effective Date: 10/01/1995

Revised Date:

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

I. PURPOSE

This policy defines the ~~guidelines for framework~~ under which maternal health services shall be delivered. It ensures consistent and equitable care across the provision continuum of Perinatal Support Services (PSS) pregnancy and postpartum services through structured oversight, coordination, and quality improvement activities to ~~optimize~~ Member ~~outcomes~~.

II. POLICY

~~A.~~ CalOptima Health shall ~~be responsible~~ ensure coverage and access to medically necessary maternal health services for all eligible Members.

~~A.B.~~ Members shall have timely access to obstetric providers, including nurse midwives and licensed midwives, within the provision of PSS to a Member ~~contracted network~~, without unnecessary barriers, including prior authorization requirements where prohibited.

~~B.~~ CalOptima Health shall refer a Member to a Contracted Provider for obstetric services.

~~C.~~ CalOptima Health and delegated Health Networks must ensure coverage of prenatal care as soon as pregnancy is identified and must not require Prior Authorization for basic prenatal, maternal, and preventive services and care, as defined by the most current clinical standards or guidelines of American College of Obstetricians and Gynecologist (ACOG) and Comprehensive Perinatal Services Program (CPSP).

~~D.~~ CalOptima Health, delegated Health Networks, and Contracted Providers must ensure timely access to all medically necessary covered Services as defined by the most current clinical standards or guidelines of ACOG and CPSP, including midwifery services, Doula services, lactation services, Transitions of Care (TCS), Enhanced Care Management (ECM), and Community Supports, as applicable, for which they qualify.

1. Ensure timely access to abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements outlined in the Medi-Cal Provider Manual: Abortions.

1 C.E. CalOptima Health shall provide Members an opportunity to participate in enhanced perinatal support
2 services through the Comprehensive Perinatal Services Program (CPSP) in accordance with the California
3 Department of Health Care Services (DHCS) Comprehensive Perinatal Services Program and California
4 Welfare and Institutions Code, section 14134.5; Title 22, California Code of Regulations (CCR), sections
5 51179 et seq., 51348 and 51504; and the American Rescue Plan Act of 2021 (ARPA).

6
7 ~~D. The Medi-Cal postpartum coverage period shall be twelve (12) months. The twelve (12) month~~
8 ~~postpartum coverage period for Medi-Cal eligible pregnant individuals will begin on the day following~~
9 ~~the last day of the pregnancy and will end on the last day of the month in which the 365th day occurs.~~
10 ~~Individuals will maintain coverage through their pregnancy and twelve (12) month extended postpartum~~
11 ~~coverage period regardless of income changes, citizenship, or immigration status.~~

12
13 1. Comprehensive perinatal services shall include obstetric, psychosocial, nutrition, and health education
14 services, and related case coordination provided by or under the personal supervision of a physician
15 during pregnancy, and postpartum period to include twelve (12) months ~~(365 days)~~ after the last day
16 of pregnancy ~~(365 days)~~, or in accordance with the CPSP and ACOG guidelines.

17
18 2. CalOptima Health shall not require Prior Authorization for CPSP. However, Prior Authorization is
19 required if the amount of services exceeds the maximum frequency amounts as set forth in Title 22,
20 California Code of Regulations (CCR) section 51504.

21
22 3. Maternity Providers, including non-physician providers, are not required to enroll as a CPSP
23 Provider.

24
25 4. A Member shall have the right to refuse CPSP.

26
27 F. The Medi-Cal postpartum coverage period shall be twelve (12) months. The twelve (12) month
28 postpartum coverage period for Medi-Cal eligible pregnant individuals will begin on the day following
29 the last day of the pregnancy and will end on the last day of the month in which the 365th day occurs.

30
31 G. Transitional Care Services (TCS) shall be provided for all pregnant members or members in the
32 postpartum period in accordance with CalOptima Health Policy GG.1357: Population Health
33 Management Transitional Care Services (TCS).

34
35 H. CalOptima Health, delegated Health Networks, and Contracted Providers must cover Medically
36 Necessary manual and electric breast pumps (including wearable breast pumps that are cordless or
37 wireless) and breast pump supplies, as well as replacement breast pump supplies (which are considered
38 lactation durable medical equipment (DME) for breastfeeding Members as a Medi-Cal benefit in
39 accordance with CalOptima Health Policy GG.1704: Breastfeeding Promotion.

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41 ~~E.I.~~ A Contracted Provider providing care to CalOptima Health Members shall cover up to twenty (20)
42 individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk
43 factors for perinatal depression when sessions are delivered during the prenatal period and/or during the
44 twelve (12) months following childbirth as set forth in the ~~Department of Health Care Services (DHCS)~~
45 All Plan Letter (APL) ~~22-00626-002~~: Medi-Cal Managed Care ~~Health~~ Plan Responsibilities for Non-
46 Specialty Mental Health Services, and in accordance with CalOptima Health ~~Policy~~ Policies CC.1400:
47 Behavioral Health Services and GG.1900: Behavioral Health Services.

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49 J. CalOptima Health Contracted Providers shall implement a comprehensive risk assessment tool for
50 identified pregnant Members that is comparable to American College of Obstetricians and Gynecologists
51 (ACOG) and/or CPSP standards ~~at an early prenatal visit, once each trimester thereafter, and at the~~
52 ~~postpartum visit. The results of these assessments must be maintained as part of the Member's Medical~~
53 Record.

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1. Individual care plans (ICP) must be developed by Contracted Providers to include obstetrical, nutrition, psychosocial, and health education assessments and interventions when indicated by identified risk factors as set forth in the Department of Health Care Services (DHCS) Policy Letter (PL) 12-003: Obstetrical Care Perinatal Services DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members. The risk assessment may be completed in person or virtually through a Telehealth visit, in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services.

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K. CalOptima Health and its Health Networks shall ensure that pregnant and postpartum Members identified as high-risk are referred to appropriate Specialists or services based on the Member's clinical needs

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F.L. CalOptima Health shall cover a Member's prenatal labor and delivery, or postpartum care services provided by a Freestanding Birth Centers (FBC) as set forth in the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members.

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1. CalOptima Health shall refer Members to appropriate hospitals within its network that provide necessary high-risk pregnancy and delivery services, as appropriate.

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M. CalOptima Health shall not require Prior Authorization for PSS CalOptima Health shall ensure the provision of folic acid vitamins for Members trying to become pregnant, are pregnant, postpartum and breastfeeding in alignment with current American College of Obstetricians and Gynecologists (ACOG) guidelines which are covered by Medi-Cal Rx.

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2.1. Contracted Providers. However, Prior Authorization is required if the amount of services exceeds the maximum frequency amounts as set forth in Title 22, California Code of Regulations (CCR) section 51504.

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G. A Contracted Provider providing prenatal and postpartum care to CalOptima Health Members shall meet the requirements for service provision as set forth in Department of Health Care Services (DHCS) Policy Letter (PL) 12-003: Obstetrical Care Perinatal Services and defined in CalOptima Health's Contract for Public Health Services with Orange County Health Care Agency.

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H.N. Primary Care Providers (PCP), Health Networks, and CalOptima Health shall refer pregnant and postpartum Members to a Doula provider who is able to render services, if a Member requests Doula support services that are within Medi-Cal program requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

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1. Access to doula services as a covered Medi-Cal benefit including health education, advocacy, and physical, emotional, and non-medical support before, during, and after birth, including support for miscarriage, stillbirth, and abortion in accordance with DHCS APL 23-024: Doula Services and CalOptima Health Policy GG.1707: Doula Services.

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I.O. A Contracted Provider, Health Network, or CalOptima Health shall document referrals in the Member's Medical Record and provide the Member with referrals to:

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1. Women, Infants and Children (WIC). Referrals should be completed as soon as the Member is identified as pregnant, using the WIC referral process, and documented in the Member's chart including referral date, or refusal, and lab values, if available. Members who shall be referred include: pregnant, postpartum and pediatric members consistent with WIC program eligibility criteria to support continuity of nutrition support;

- a. ~~Women who are pregnant;~~
- b. ~~Breastfeeding women up to one (1) year after delivery;~~
- c. ~~Non-breastfeeding women up to six (6) months after delivery;~~
- d. ~~Infants from birth to one (1) year of age; and~~
- e. ~~Children from one (1) to five (5) years of age.~~

2. DHCS approved genetic diagnostic center for screening services, in accordance with CalOptima Health Policy GG.1109: CalOptima Health and Health Network Newborn and Prenatal Genetic Screening Services, if necessary;

3. ~~Dental services, if necessary; Referrals to Enhanced Care Management (ECM) for eligible pregnant or postpartum members which can qualify under any eligibility criteria, in accordance with CalOptima Health Policy GG.1354: CalAIM Enhanced Care Management – Eligibility and Outreach.~~

- 3.4. ~~Ensure that dental screenings and oral health assessments are offered and coordinated for all pregnant and postpartum Members, including throughout pregnancy and the twelve (12)-month postpartum period, in alignment with the most current American College of Obstetricians and Gynecologists (ACOG) guidelines. Dental screenings and oral health assessments which can be conducted by primary care or maternity care teams;~~

- 4.5. ~~Other public benefits and community resources to address individual Member's social, mental, and physical health needs; and~~

- 5.6. ~~Other services, as needed.~~

~~J.P.~~ A Contracted Provider, Health Network, and/or CalOptima Health shall:

1. Provide Members at high risk of a poor pregnancy outcome:
 - a. Timely referrals to specialists, including Perinatologists, in accordance with CalOptima Health ~~Policy Policies CC.1700: Standards of Accessibility and Timely Access and~~ GG.1600: Access and Availability Standards; and
 - b. Referrals to DHCS-approved genetic diagnostic center for screening services, in accordance with CalOptima Health Policy GG.1109: CalOptima Health and Health Network Newborn and Prenatal Genetic Screening Services, including follow up services.
2. Promote breastfeeding to a Member, in accordance with CalOptima Health Policy GG.1704: Breastfeeding Promotion; ~~Services can be provided by lactation consultants or other trained staff, either within the practice under a licensed provider's oversight or through referral to outside servicers in accordance with DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal members.~~
 - a. ~~Lactation consultation services must be provided by knowledgeable health practitioners experienced in providing lactation services, such as physicians, RNs (including CNMs and nurse practitioners), and dietitians under the direction of a physician.~~

b. Cover and arrange for the provision of Medically Necessary pasteurized donor human breast milk for newborns of Members who are unable to breastfeed due to medical reasons; whose infant(s) cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas; and/or has another situation for which donor human breast milk is deemed Medically Necessary by a Medi-Cal Provider.

3. Provide syphilis screening and testing as outlined in the most recent guidelines published by the State Department of Public Health, per Health and Safety Code, Division 105;
4. ~~Promote~~ timely immunizations with members receiving prenatal and postpartum care in accordance with the most recent schedule and recommendations, in accordance with ~~Department of Health Care Services (DHCS) All Plan Letter (APL)~~ DHCS APL 24-008: Immunization Requirements and CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities;
5. Document each Member's need for the Advisory Committee on Immunization Practices (ACIP)-recommended immunization as part of all regular health visits, including, but not limited to prenatal and postpartum care visits, in accordance with ~~Department of Health Care Services (DHCS) All Plan Letter (APL)~~ DHCS APL 24-008: Immunization Requirements;
6. Evaluate a Member for domestic abuse and report suspected or observed abuse, in accordance with the provisions of this Policy and CalOptima Health Policy GG.1706: Child Abuse Report;
7. Discuss with the Member any concerns regarding prenatal care, services, or any of the information provided by the Contracted Provider; and
8. Address Maternal Mental Health (MMH) prenatally and postpartum by implementing a standardized screening tool. Members at risk of MMH conditions shall receive follow-up care within thirty (30) days of the screening.

~~K. A Member shall have the right to refuse CPSP and CalOptima Health's Bright Steps program.~~

~~L.Q.~~ CalOptima Health shall maintain a Memorandum of Understanding (MOU) with the local County WIC program for the coordination of WIC and Maternal, Child and Adolescent Health (MCAH) services provided to Members.

~~R. CalOptima Health, Health Networks and Contracted Providers shall ensure the below requirements outlined in this section to apply specifically to Mmembers enrolled in Covered California and shall be implemented in accordance with applicable Covered California contractual, regulatory and program requirements.~~

1. Screen pregnant and postpartum patients for maternal mental health conditions, such as depression and anxiety, during specified prenatal and postpartum visits.
2. Ensure usage of standardized screening tools.
3. Referrals to appropriate mental health services or resources if a screening indicates a potential mental health condition.

~~S. Health Networks shall promote and encourage all network hospitals that provide pregnancy and postpartum services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).~~

~~T. Ensure the provision of medically necessary perinatal durable medical equipment, including breast~~

pumps, consistent with Covered California requirements.

U. Report annually on efforts made to engage with providers and Enrollees undergoing pregnancy, childbirth, and postpartum care to promote:

1. Pregnant and postpartum care options for the delivery of high-value care—right provider, right setting, right price—with accessible care options including same-day services for urgent needs and special considerations for patients with high-risk pregnancies;
2. Ensuring comprehensive safe and supportive pregnancy and postpartum care that promotes health, resilience, and disease prevention for the pregnant and postpartum patient and their family;
3. Education and support throughout all phases of pregnancy and postpartum care to empower informed decision-making and promote positive health outcomes. This includes sharing safety ratings, promoting the appropriate use of C-sections, and offering educational resources to individuals and families to ensure they receive patient-centered, appropriate care while avoiding unnecessary interventions;
4. Whole person care as defined by Cal Healthcare Compare’s Maternity Honor Roll Program; and
5. Promote and offer doula services.

V. Track and report the number in-network doulas, certified nurse midwives, and licensed midwives and include in development and submission of a network expansion strategy for the recruitment of a diverse network of care navigators, for racial and ethnic congruency between provider and members and increased access to Maternal health services that encompass the full spectrum of pregnancy, childbirth, and postpartum care.

W. Member access to doula and midwifery care when delivering services that are included as essential health benefits, including birth centers and home birth, to reduce administrative barriers and incentivize coordinated team-based care.

X. Provide member information and awareness regarding accessibility of enterprise and local social support services available, such as food, housing, and transportation programs and resources.

Y. Monitor and reduce maternal mental health disparities by providing medically necessary therapy, crisis intervention for perinatal mood disorders, and evidence-based SUD programs, including Medication Assisted Treatment (MAT) and harm reduction strategies, with coordinated care across behavioral health, obstetric, and pediatric providers.

Z. Collect measure results, stratified by race and ethnicity, for its Covered California Enrollees and submit patient level data files for the following HEDIS measures in accordance with Article 1.02.1 for:

1. Prenatal Depression Screening and Follow-up (PND-E), and
2. Postpartum Depression Screening and Follow-up (PDS-E)
3. Review its performance, stratified by race and ethnicity, on the Prenatal and Postpartum Care (PPC) measure results generated by Covered California using Contractor’s HEI data.

AA. Implement at least one intervention, as determined by CalOptima Health, to identify and address health disparities among identified subpopulations. Interventions shall incorporate quality and health equity measures and support efforts to improve equitable health outcomes for Covered California members.

III. PROCEDURE

- A. A Contracted Provider shall inform CalOptima Health of a Member's- first (1st) obstetric visit within five (5) calendar days after the visit by submitting a completed CalOptima Health Pregnancy Notification Report (PNR) form to CalOptima Health.
- ~~B. CalOptima Health shall provide bi-weekly reports to the Member's Health Network's for whom CalOptima Network if the Member has identified as potentially pregnant or postpartum. Health received a PNR within the previous fourteen (14) calendar days.~~
- ~~C.B. CalOptima Health's Population Health Management Department shall review the PNR Networks are encouraged to identify their pregnant and refer a Member who is not receiving PSS postpartum mMembers through a certified CPSP Provider to the Bright Steps Program. their systems to increase early identification.~~
- ~~D.C. If a Member's Contracted Provider documents high risk pregnancy factors on the Member's PNR, the Contracted Provider, CalOptima Health or the Member's Health Network, ECM Provider or Community Support shall provide the Member with Case Management, in accordance with CalOptima Health Policy GG.1301: Comprehensive Case Management Process.~~
- ~~E. CalOptima Health shall provide PSS to a Member as follows:~~
- ~~1. Upon receipt of a PNR form from the Contracted Provider or a Health Network, CalOptima Health shall refer the Member to Bright Steps, unless there is documentation that services are being provided through a certified CPSP Provider.~~
 - ~~2. Upon receipt of a referral from CalOptima Health, Bright Steps shall contact the Member to offer PSS.~~
 - ~~3. If a Member chooses not to participate in Bright Steps, Bright Steps shall notify the Member's Contracted Provider that submitted a PNR. The Contracted Provider shall document the refusal on the Member's Medical Record and provide the Member with the following:~~
 - ~~a. Pregnancy education materials;~~
 - ~~b. Breastfeeding education and materials; and~~
 - ~~c. A referral to WIC and other community resources, as needed.~~
- ~~D. A pregnant or postpartum Member shall be considered high-risk if identified by: (a) a Network Provider's clinical assessment; (b) criteria for high-intensity pregnancy and postpartum Transitional Care Services (TCS), including medical, behavioral health, and social risk factors, in accordance with the Population Health Management Policy Guide and CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS); or (c) Medi-Cal's Risk Stratification, Segmentation, and Tiering (RSST) Algorithm.~~
- ~~E. Screen Mmembers for depression using a validated, standardized screening tool at least once during the prenatal period and during the postpartum period. Members who screen positive for depression shall receive timely follow-up and care coordination no more than thirty (30) days of a positive screening result.~~

- 1 F. Screen members for Adverse Childhood Effects (ACEs) using a standardized screening tool. If members
2 screen positive a provider shall ensure medically necessary follow-up services and care.
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- 4 G. Per state law, as of January 1, 2025, all general acute care hospitals and special hospitals in California
5 must adopt the “Ten Steps to Successful Breastfeeding,” as adopted by Baby-Friendly USA, per the
6 Baby-Friendly Hospital Initiative (designation available for five years), or an alternate process adopted by
7 a health care service plan that includes evidence-based policies and practices and targeted outcomes, or
8 adopt the Model Hospital Policy Recommendations developed by CDPH.
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- 10 1. By December 31, 2028, hospitals that have maternity units the requirement that they comply with this
11 state law to be Baby-Friendly designated; or adopt the CDPH Model Hospital Policy
12 Recommendations; or adopt an alternate process adopted by a health care service plan that includes
13 evidence-based policies and practices and targeted outcomes, as identified in state law.
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- 15 H. Individual care plans must be developed by Contracted Providers to include obstetrical, nutrition,
16 psychosocial, and health education assessments and interventions when indicated by identified risk factors
17 as set forth in the DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal
18 members. The risk assessment may be completed in person or virtually through a Telehealth visit, an early
19 prenatal visit, once each trimester thereafter, and at the postpartum visit in accordance with CalOptima
20 Health Policy GG.1665: Telehealth and Other Technology-Enabled Services.
21
- 22 1. Intimate partner violence (IPV) screening must be incorporated in the comprehensive risk assessment
23 at the initial prenatal appointment – or at an alternative prenatal appointment – and when the risk
24 assessment is repeated each trimester and during the postpartum assessment, ensuring safe disclosure
25 without the presence of an intimate partner.
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- 27 I. Timely referrals to specialists, in accordance with CalOptima Health Policies CC.1700: Standards of
28 Accessibility and Timely Access and GG.1600: Access and Availability Standards. Appropriate high-risk
29 pregnancy referrals may include obstetric specialists, maternal-fetal medicine, behavioral health services,
30 care management, Enhanced Care Management, Community Supports, or other medically necessary
31 services
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- 33 J. Offer information about participating in the California Prenatal Screening (CA PNS) Program to all
34 pregnant members who engage in care before twenty-one (21) weeks zero (0) days gestation for the
35 detection of pregnancies at increased risk for carrying a fetus with chromosomal abnormalities, sex
36 chromosome aneuploidies, or neural tube defects.
37
- 38 1. If a Member receives a positive or inconclusive CA PNS Program screening test result, then a
39 regional CA PNS Program Coordinator will contact the prenatal Provider, who will provide a referral
40 for necessary follow-up counseling and diagnostic services at state-approved Prenatal Diagnosis
41 Centers (PDCs)
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- 43 2. Documentation of consent/declination and referrals must be kept in the Member's Medical Record
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- 45 3. Ensure all newborns are screened for over eighty (80) serious but treatable genetic (passed down in
46 families) and congenital (present at birth) disorders through the California Newborn Screening (CA
47 NBS) Program, unless they opt out of screening for religious beliefs or practice which must be
48 documented in the Member's Medical Record. The CA NBS Program specimen collection must
49 occur between twelve (12) and forty-eight (48) hours after birth, unless otherwise medically indicated.
50
- 51 F.K. If the Member agrees to participate in CPSP or Bright Steps, the Contracted Provider or Bright Steps
52 shall provide prenatal and postpartum care in accordance with this Policy.
53

1. CalOptima Health shall not require Prior Authorization for CPSP. However, Prior Authorization is required if the amount of services exceeds the maximum frequency amounts as set forth in Title 22, California Code of Regulations (CCR) section 51504.

2. CalOptima Health shall provide CPSP to a pregnant Member for the duration of her pregnancy and through the postpartum period to include twelve (12) months (365 days) after the last day of pregnancy ~~-(365 days)-~~, or in accordance with the CPSP guidelines.

~~G.L.~~ CHW services may be provided virtually through a telehealth visit with the Member's consent. Pregnant and postpartum members may receive up to six hours annually of Medi-Cal covered CHW services from a CHW operating under the supervision of an enrolled CHW Supervising Provider in accordance with DHCS APL 24-006: Community Health Worker Services Benefit, the Medi-Cal Provider Manual: CHW Preventive Services, and DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members.

~~H.M.~~ A Contracted Provider shall complete a WIC referral form in accordance with WIC guidelines and document the date the Member was referred to WIC in the Member's Medical Record.

~~I.N.~~ A Contracted Provider shall continue to provide obstetrical services to the Member in accordance with ACOG standards even if the Practitioner does not provide ~~PSSCPSP~~ to the Member. These services include referrals to:

1. Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) testing, information, and counseling services; and
2. DHCS approved genetic diagnostic center, if necessary.

~~I.O.~~ Monitoring and Reporting Requirements

1. On a quarterly basis, the ~~Population Health Management Department~~ Clinical Operations shall monitor and report on the availability of ~~PSS services~~ maternal health quality measures for Members. Aggregate reports shall include information on the following during the reporting period:

~~a. Percentage of PNRs received compared to annual deliveries;~~

~~b. Percentage of deliveries that participated in Bright Steps or with CPSP Provider;~~

~~e.a.~~ Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment date or within forty-two (42) calendar days of enrollment in CalOptima Health.

~~d.b.~~ Timeliness of Postpartum Care: Percentage of deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) calendar days after delivery.

c. The percentage of deliveries in which persons were screened for clinical depression using a standardized instrument during the prenatal and postpartum period.

d. The percentage of deliveries in which persons received follow-up care within thirty (30) days of a positive depression screen finding.

2. CalOptima Health ~~PHM~~ will review and evaluate birth outcome data annually using claims, authorization data, HEDIS performance, and other relevant data sources to guide ~~Bright Steps~~ Maternal Health program planning and enhancements.

3. The ~~Population Health Management~~Clinical Operations Department shall submit the reports to the CalOptima Health Quality Improvement (QI) Committee for the evaluation and monitoring of ~~PSS~~Maternal Health Services, in accordance with the Quality Improvement (QI) Work Plan.
4. Delegated Health Networks and Providers shall comply with all applicable regulatory, contractual, state, and federal requirements related to maternal health, prenatal care, postpartum care and associated members services. Compliance with these requirements is subject to monitoring, oversight, and audit at any time to ensure completion of all required activities, documentation, and standards of care.
- 4.5. CalOptima Health shall ensure ~~provider~~Provider compliance with this Policy by conducting a record review in accordance with guidance from the ~~Department of Health Care Services (DHCS)~~DHCS and CalOptima Health Policy GG.1608: Full Scope Site Reviews.
- 5.6. Perinatal services out of compliance with DHCS standards for care and delivering programs and/or frequency of reporting requirements shall be subject to a Focused Review or require a Corrective Action Plan (CAP) if the issue remains unresolved, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

- ~~A. CalOptima Health Pregnancy Notification Report (PNR)~~
~~B.A. WIC Referral for Postpartum/Breastfeeding Women~~
~~C.A. WIC Pediatric Referral~~
~~D.A. WIC Referral for Pregnant Women~~

V. REFERENCE(S)

- ~~E.A.~~ American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care
B. American Rescue Plan Act (ARPA) of 2021
~~F.C.~~ California Department of Health Care Services (DHCS) Comprehensive Perinatal Services Program Provider Handbook
~~G.D.~~ California Welfare and Institutions Code, §14134.5
~~H.E.~~ CalOptima Health Contract for Health Care Services
~~I.F.~~ CalOptima Health Contract for Public Health Services with the Orange County Health Care Agency
~~J.G.~~ CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~K.H.~~ CalOptima Health Initial Outreach and Referral Process for Perinatal Support Services (PSS)
I. CalOptima Health Policy CC.1400: Behavioral Health Services
J. CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access
~~L.K.~~ CalOptima Health Policy GG.1109: CalOptima Health and Health Network Newborn and Prenatal Genetic Screening Services
~~M.L.~~ CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
~~N.M.~~ CalOptima Health Policy GG.1301: Comprehensive Care Management Process
N. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS)
O. CalOptima Health Policy GG.1600: Access and Availability Standards
P. CalOptima Health Policy GG.1608: Full Scope Site Reviews
Q. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
R. CalOptima Health Policy GG.1704: Breastfeeding Promotion
S. CalOptima Health Policy GG.1706: Child Abuse Report
T. CalOptima Health Policy GG.1707: Doula Services
U. CalOptima Health Policy GG.1900: Behavioral Health Services

- V. CalOptima Health Policy HH.2002: Sanctions
- W. CalOptima Health Policy HH.2005: Corrective Action Plan
- X. CalOptima Health Pregnancy Notification Report (PNR)
- ~~X.Y.~~ Department of Health Care Services (DHCS) ~~Policy All Plan~~ Letter (PL) 12-003: Obstetrical Care—
Perinatal (APL) 23-024: Doula Services (Supersedes ~~PL 12-001 and 96-01~~ APL 22-031) (Revised
11/3/2023)
- ~~Y.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for
Freestanding Birth Centers and the Provision of Midwife Services (Supersedes APL 16-017)
- Z. ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 22-24-006: Medi-Cal Managed
Care Community Health Plan Responsibilities for Non-Specialty Mental Health Worker Services Benefit~~
(Supersedes APL 17-018 22-016)
- AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization
Requirements (Supersedes APL 18-004 and 16-009)
- BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed Care
Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)
- CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-005: Maternity Services for
Pregnant and Postpartum Medi-Cal Members (Supersedes APLs 00-012, 18-022, and Policy Letters 98-
006, 98-010, and 12-003)
- ~~BB.A. American Rescue Plan Act (ARPA) of 2021~~
- ~~CC.DD.~~ Health and Safety Code, Division 105
- ~~DD.EE.~~ Title 22 California Code of Regulations (C.C.R.), §§ 51179 et seq., 51348 and 51504.
- ~~EE.FF.~~ Title 42 Code of Federal Regulations (C.F.R.), § 431.635(c)
- GG. WIC Pediatric Referral
- HH. WIC Referral for Postpartum/Breastfeeding Women
- II. WIC Referral for Pregnant Women

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/04/2015	Department of Health Care Services (DHCS)	Approved as Submitted
08/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/02/2022	Department of Health Care Services (DHCS)	Approved as Submitted
07/29/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
03/22/2024	Department of Health Care Services (DHCS)	File and Use
07/29/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	05/01/1999	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	05/01/2000	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2007	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	01/01/2008	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	07/01/2015	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	09/01/2016	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	10/01/2017	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	10/01/2018	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	02/01/2019	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	08/01/2021	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	04/01/2022	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	07/01/2022	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	07/01/2022	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	04/01/2023	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	08/01/2023	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	03/01/2024	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	08/01/2024	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	09/01/2025	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
<u>Revised</u>		<u>GG.1701</u>	<u>Maternity Services for Pregnant and Postpartum Members</u>	<u>Covered California Medi-Cal</u>

IX. GLOSSARY

Term	Definition
Bright Steps Program	CalOptima Health's pregnancy, postpartum and infant program that provides perinatal support services to Medi-Cal members. Services are offered to members for the duration of their pregnancy and up to one (1) year after delivery. Services include nutrition, health education, psychosocial assessments, referrals, and other appropriate interventions.
Comprehensive Perinatal Services Program (CPSP)	Services as defined in Welfare and Institutions Code, Section 14134.5, and Title 22, California Code of Regulations, Sections 51179 et seq., 51348 and 51504. For CalOptima Health members, CPSP is incorporated into CalOptima Health's Perinatal Support Services.
Comprehensive Perinatal Service (CPSP) Provider (CPSP)	Any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, family or pediatric nurse practitioner, alternative birth center, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic holding a valid and current Medi-Cal provider number and certified pursuant to the standards of this section.
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima Health, its contracted Health Networks or Physician Medical Groups.
Corrective Action Plan (CAP)	<u>Covered California:</u> <u>Medi-Cal:</u> 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.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.
Focused Review	An audit that specifically targets areas of potential deficiency.
Freestanding Birth Center (FBC)	A health facility that is not a hospital where childbirth is planned to occur away from the pregnant woman's residence, and that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(I)(3)(B).
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.

Term	Definition
High-Risk <u>Perinatal Member</u>	A Member who has failed to take advantage of necessary health care services, does not comply with his or her medical regimen, needs coordination of multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, suffering from substance abuse, or is the victim of abuse, neglect, or violence, including, but not limited to, the following: 1. Infants; 2. Women; 3. Persons less than twenty one (21) years of age; 4. Persons with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS); 5. Persons with a reportable communicable disease; 6. Persons who are technology dependent; 7. Persons with multiple diagnoses who require services from multiple health or social service providers; or <u>Persons who are medically fragile. Pregnant and postpartum individuals (up to 12 months after pregnancy ends) who are identified as needing intensive care management due to clinical, social, or behavioral health factors, hospitalizations, or a provider deems the member high-risk.</u>
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 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. An individual enrolled in a CalOptima Health program.
<u>Perinatal Support Services (PSS)</u>	<u>Perinatal services as defined in the Contract for PSS.</u>
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.
Prior Authorization	<u>Covered California: 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).</u> <u>Medi-Cal: A formal process requiring a Provider to obtain advanceadvanced approval for the amount, duration, and scope of non-emergent Covered Services.</u>
Provider	<u>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.</u> <u>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.</u>
<u>Transitional Care Services (TCS)</u>	<u>Care transitions are defined as a member transferring from one setting or level of care to another. Supporting members across all settings and delivery</u>

Term	Definition
	<u>systems to ensure members are supported from discharge planning until successful connection to all needed services and supports.</u>
Women, Infants, and Children (WIC)	The special supplemental nutrition program for women, infants, and children, authorized by section 17 of the Child Nutrition Act of 1966, 42 U.S.C. 1786.

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For 20261001 BOD Review Only

Policy: GG.1701
 Title: **Maternity Services for Pregnant and Postpartum Members**
 Department: Case Management
 Section: Not Applicable

CEO Approval: /s/

Effective Date: 10/01/1995

Revised Date: TBD

Applicable to:

- ☐ Administrative
- ☒ Covered California
- ☒ Medi-Cal
- ☐ OneCare
- ☐ PACE

I. PURPOSE

This policy defines the framework under which maternal health services shall be delivered. It ensures consistent and equitable care across the continuum of pregnancy and postpartum services through structured oversight, coordination, and quality improvement activities to optimize Member outcomes.

II. POLICY

- A. CalOptima Health shall ensure coverage and access to medically necessary maternal health services for all eligible Members.
- B. Members shall have timely access to obstetric providers, including nurse midwives and licensed midwives, within the contracted network, without unnecessary barriers, including prior authorization requirements where prohibited.
- C. CalOptima Health and delegated Health Networks must ensure coverage of prenatal care as soon as pregnancy is identified and must not require Prior Authorization for basic prenatal, maternal, and preventive services and care, as defined by the most current clinical standards or guidelines of American College of Obstetricians and Gynecologist (ACOG) and Comprehensive Perinatal Services Program (CPSP).
- D. CalOptima Health, delegated Health Networks, and Contracted Providers must ensure timely access to all medically necessary covered Services as defined by the most current clinical standards or guidelines of ACOG and CPSP, including midwifery services, Doula services, lactation services, Transitions of Care (TCS), Enhanced Care Management (ECM), and Community Supports, as applicable, for which they qualify.
 1. Ensure timely access to abortion services, as well as the medical services and supplies incidental or preliminary to an abortion, consistent with the requirements outlined in the Medi-Cal Provider Manual: Abortions.
- E. CalOptima Health shall provide Members an opportunity to participate in enhanced perinatal support services through the Comprehensive Perinatal Services Program (CPSP) in accordance with the California Department of Health Care Services (DHCS) Comprehensive Perinatal Services Program and California Welfare and Institutions Code, section 14134.5; Title 22, California Code of Regulations (CCR), sections 51179 et seq., 51348 and 51504; and the American Rescue Plan Act of 2021 (ARPA).

1. Comprehensive perinatal services shall include obstetric, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy, and postpartum period to include twelve (12) months (365 days) after the last day of pregnancy, or in accordance with the CPSP and ACOG guidelines.
 2. CalOptima Health shall not require Prior Authorization for CPSP. However, Prior Authorization is required if the amount of services exceeds the maximum frequency amounts as set forth in Title 22, California Code of Regulations (CCR) section 51504.
 3. Maternity Providers, including non-physician providers, are not required to enroll as a CPSP Provider.
 4. A Member shall have the right to refuse CPSP.
- F. The Medi-Cal postpartum coverage period shall be twelve (12) months. The twelve (12) month postpartum coverage period for Medi-Cal eligible pregnant individuals will begin on the day following the last day of the pregnancy and will end on the last day of the month in which the 365th day occurs.
- G. Transitional Care Services (TCS) shall be provided for all pregnant members or members in the postpartum period in accordance with CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS).
- H. CalOptima Health, delegated Health Networks, and Contracted Providers must cover Medically Necessary manual and electric breast pumps (including wearable breast pumps that are cordless or wireless) and breast pump supplies, as well as replacement breast pump supplies (which are considered lactation durable medical equipment (DME) for breastfeeding Members as a Medi-Cal benefit in accordance with CalOptima Health Policy GG.1704: Breastfeeding Promotion.
- I. A Contracted Provider providing care to CalOptima Health Members shall cover up to twenty (20) individual and/or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the twelve (12) months following childbirth as set forth in the DHCS All Plan Letter (APL) 26-002: Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services, and in accordance with CalOptima Health Policies CC.1400: Behavioral Health Services and GG.1900: Behavioral Health Services.
- J. Contracted Providers shall implement a comprehensive risk assessment tool for identified pregnant Members that is comparable to American College of Obstetricians and Gynecologists (ACOG) and/or CPSP standards at an early prenatal visit, once each trimester thereafter, and at the postpartum visit. The results of these assessments must be maintained as part of the Member's Medical Record.
1. Individual care plans (ICP) must be developed by Contracted Providers to include obstetrical, nutrition, psychosocial, and health education assessments and interventions when indicated by identified risk factors as set forth in the DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members. The risk assessment may be completed in person or virtually through a Telehealth visit, in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services.
- K. CalOptima Health and its Health Networks shall ensure that pregnant and postpartum Members identified as high-risk are referred to appropriate Specialists or services based on the Member's clinical needs

- 1 L. CalOptima Health shall cover a Member's prenatal labor and delivery, or postpartum care services
2 provided by a Freestanding Birth Centers (FBC) as set forth in the Department of Health Care Services
3 DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members.
4
- 5 1. CalOptima Health shall refer Members to appropriate hospitals within its network that provide
6 necessary high-risk pregnancy and delivery services, as appropriate.
7
- 8 M. CalOptima Health shall ensure the provision of folic acid vitamins for Members trying to become
9 pregnant, are pregnant, postpartum and breastfeeding in alignment with current American College of
10 Obstetricians and Gynecologists (ACOG) guidelines which are covered by Medi-Cal Rx.
11
- 12 N. Contracted Providers, Health Networks, and CalOptima Health shall refer pregnant and postpartum
13 Members to a Doula provider who is able to render services, if a Member requests Doula support services
14 that are within Medi-Cal program requirements, in accordance with CalOptima Health Policy GG.1707:
15 Doula Services.
16
- 17 1. Access to doula services as a covered Medi-Cal benefit including health education, advocacy, and
18 physical, emotional, and non-medical support before, during, and after birth, including support for
19 miscarriage, stillbirth, and abortion in accordance with DHCS APL 23-024: Doula Services and
20 CalOptima Health Policy GG.1707: Doula Services.
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- 22 O. A Contracted Provider, Health Network, or CalOptima Health shall document referrals in the Member's
23 Medical Record and provide the Member with referrals to:
24
- 25 1. Women, Infants and Children (WIC). Referrals should be completed as soon as the Member is
26 identified as pregnant, using the WIC referral process, and documented in the Member's chart
27 including referral date, or refusal, and lab values, if available. Members who shall be referred
28 include pregnant, postpartum and pediatric members consistent with WIC program eligibility
29 criteria to support continuity of nutrition support;
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- 31 2. DHCS approved genetic diagnostic center for screening services, in accordance with CalOptima
32 Health Policy GG.1109: CalOptima Health and Health Network Newborn and Prenatal Genetic
33 Screening Services, if necessary;
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- 35 3. Referrals to Enhanced Care Management (ECM) for eligible pregnant or postpartum members which
36 can qualify under any eligibility criteria, in accordance with CalOptima Health Policy GG.1354:
37 CalAIM Enhanced Care Management – Eligibility and Outreach.
38
- 39 4. Ensure that dental screenings and oral health assessments are offered and coordinated for all pregnant
40 and postpartum Members, including throughout pregnancy and the twelve (12)-month postpartum
41 period, in alignment with the most current American College of Obstetricians and Gynecologists
42 (ACOG) guidelines. Dental screenings and oral health assessments which can be conducted by
43 primary care or maternity care teams;
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- 45 5. Other public benefits and community resources to address individual Member's social, mental, and
46 physical health needs; and
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- 48 6. Other services, as needed.
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- 50 P. A Contracted Provider, Health Network, and/or CalOptima Health shall:
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- 52 1. Provide Members at high risk of a poor pregnancy outcome:

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- a. Timely referrals to specialists, including Perinatologists, in accordance with CalOptima Health Policies CC.1700: Standards of Accessibility and Timely Access and GG.1600: Access and Availability Standards; and
 - b. Referrals to DHCS-approved genetic diagnostic center for screening services, in accordance with CalOptima Health Policy GG.1109: CalOptima Health and Health Network Newborn and Prenatal Genetic Screening Services, including follow up services.
2. Promote breastfeeding to a Member, in accordance with CalOptima Health Policy GG.1704: Breastfeeding Promotion. Services can be provided by lactation consultants or other trained staff, either within the practice under a licensed provider's oversight or through referral to outside servicers in accordance with DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal members.
- a. Lactation consultation services must be provided by knowledgeable health practitioners experienced in providing lactation services, such as physicians, RNs (including CNMs and nurse practitioners), and dietitians under the direction of a physician.
 - b. Cover and arrange for the provision of Medically Necessary pasteurized donor human breast milk for newborns of Members who are unable to breastfeed due to medical reasons; whose infant(s) cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas; and/or has another situation for which donor human breast milk is deemed Medically Necessary by a Medi-Cal Provider.
3. Provide syphilis screening and testing as outlined in the most recent guidelines published by the State Department of Public Health, per Health and Safety Code, Division 105;
4. Promote timely immunizations with members receiving prenatal and postpartum care in accordance with the most recent schedule and recommendations, in accordance with DHCS APL 24-008: Immunization Requirements and CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities;
5. Document each Member's need for the Advisory Committee on Immunization Practices (ACIP)-recommended immunization as part of all regular health visits, including, but not limited to prenatal and postpartum care visits, in accordance with DHCS APL 24-008: Immunization Requirements;
6. Evaluate a Member for domestic abuse and report suspected or observed abuse, in accordance with the provisions of this Policy and CalOptima Health Policy GG.1706: Child Abuse Report;
7. Discuss with the Member any concerns regarding prenatal care, services, or any of the information provided by the Contracted Provider; and
8. Address Maternal Mental Health (MMH) prenatally and postpartum by implementing a standardized screening tool. Members at risk of MMH conditions shall receive follow-up care within thirty (30) days of the screening.
- Q. CalOptima Health shall maintain a Memorandum of Understanding (MOU) with the local County WIC program for the coordination of WIC and Maternal, Child and Adolescent Health (MCAH) services provided to Members.
- R. CalOptima Health, Health Networks and Contracted Providers shall ensure the below requirements

outlined in this section to apply specifically to members enrolled in Covered California and shall be implemented in accordance with applicable Covered California contractual, regulatory and program requirements.

1. Screen pregnant and postpartum patients for maternal mental health conditions, such as depression and anxiety, during specified prenatal and postpartum visits.
 2. Ensure usage of standardized screening tools.
 3. Referrals to appropriate mental health services or resources if a screening indicates a potential mental health condition.
- S. Health Networks shall promote and encourage all network hospitals that provide pregnancy and postpartum services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).
- T. Ensure the provision of medically necessary perinatal durable medical equipment, including breast pumps, consistent with Covered California requirements.
- U. Report annually on efforts made to engage with providers and Enrollees undergoing pregnancy, childbirth, and postpartum care to promote:
1. Pregnant and postpartum care options for the delivery of high-value care—right provider, right setting, right price—with accessible care options including same-day services for urgent needs and special considerations for patients with high-risk pregnancies;
 2. Ensuring comprehensive safe and supportive pregnancy and postpartum care that promotes health, resilience, and disease prevention for the pregnant and postpartum patient and their family;
 3. Education and support throughout all phases of pregnancy and postpartum care to empower informed decision-making and promote positive health outcomes. This includes sharing safety ratings, promoting the appropriate use of C-sections, and offering educational resources to individuals and families to ensure they receive patient-centered, appropriate care while avoiding unnecessary interventions;
 4. Whole person care as defined by Cal Healthcare Compare’s Maternity Honor Roll Program; and
 5. Promote and offer doula services.
- V. Track and report the number in-network doulas, certified nurse midwives, and licensed midwives and include in development and submission of a network expansion strategy for the recruitment of a diverse network of care navigators, for racial and ethnic congruency between provider and members and increased access to Maternal health services that encompass the full spectrum of pregnancy, childbirth, and postpartum care.
- W. Member access to doula and midwifery care when delivering services that are included as essential health benefits, including birth centers and home birth, to reduce administrative barriers and incentivize coordinated team-based care.
- X. Provide member information and awareness regarding accessibility of enterprise and local social support services available, such as food, housing, and transportation programs and resources.

- 1 Y. Monitor and reduce maternal mental health disparities by providing medically necessary therapy, crisis
2 intervention for perinatal mood disorders, and evidence-based SUD programs, including Medication
3 Assisted Treatment (MAT) and harm reduction strategies, with coordinated care across behavioral health,
4 obstetric, and pediatric providers.
5
6 Z. Collect measure results, stratified by race and ethnicity, for its Covered California Enrollees and submit
7 patient level data files for the following HEDIS measures in accordance with Article 1.02.1 for:
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9 1. Prenatal Depression Screening and Follow-up (PND-E), and
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11 2. Postpartum Depression Screening and Follow-up (PDS-E)
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13 3. Review its performance, stratified by race and ethnicity, on the Prenatal and Postpartum Care (PPC)
14 measure results generated by Covered California using Contractor's HEI data.
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16 AA. Implement at least one intervention, as determined by CalOptima Health, to identify and address health
17 disparities among identified subpopulations. Interventions shall incorporate quality and health equity
18 measures and support efforts to improve equitable health outcomes for Covered California members.
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20 III. PROCEDURE

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22 A. A Contracted Provider shall inform CalOptima Health of a Member's first (1st) obstetric visit within five
23 (5) calendar days after the visit by submitting a completed CalOptima Health Pregnancy Notification
24 Report (PNR) form to CalOptima Health.
25
26 B. CalOptima Health shall provide reports to the Member's Health Network if the Member has identified
27 as potentially pregnant or postpartum. Health Networks are encouraged to identify their pregnant and
28 postpartum members through their systems to increase early identification.
29
30 C. If a Member's Contracted Provider documents high risk pregnancy factors on the Member's PNR, the
31 Contracted Provider, CalOptima Health or the Member's Health Network, ECM Provider or Community
32 Support shall provide the Member with Case Management, in accordance with CalOptima Health Policy
33 GG.1301: Comprehensive Case Management Process.
34
35 D. A pregnant or postpartum Member shall be considered high-risk if identified by: (a) a Network Provider's
36 clinical assessment; (b) criteria for high-intensity pregnancy and postpartum Transitional Care Services
37 (TCS), including medical, behavioral health, and social risk factors, in accordance with the Population
38 Health Management Policy Guide and CalOptima Health Policy GG.1357: Population Health
39 Management Transitional Care Services (TCS); or (c) Medi-Cal's Risk Stratification, Segmentation, and
40 Tiering (RSST) Algorithm.
41
42 E. Screen members for depression using a validated, standardized screening tool at least once during the
43 prenatal period and during the postpartum period. Members who screen positive for depression shall
44 receive timely follow-up and care coordination no more than thirty (30) days of a positive screening
45 result.
46
47 F. Screen members for Adverse Childhood Effects (ACEs) using a standardized screening tool. If members
48 screen positive a provider shall ensure medically necessary follow-up services and care.
49
50 G. Per state law, as of January 1, 2025, all general acute care hospitals and special hospitals in California
51 must adopt the "Ten Steps to Successful Breastfeeding," as adopted by Baby-Friendly USA, per the
52 Baby-Friendly Hospital Initiative (designation available for five years), or an alternate process adopted by

a health care service plan that includes evidence-based policies and practices and targeted outcomes, or adopt the Model Hospital Policy Recommendations developed by CDPH.

1. By December 31, 2028, hospitals that have maternity units the requirement that they comply with this state law to be Baby-Friendly designated; or adopt the CDPH Model Hospital Policy Recommendations; or adopt an alternate process adopted by a health care service plan that includes evidence-based policies and practices and targeted outcomes, as identified in state law.
- H. Individual care plans must be developed by Contracted Providers to include obstetrical, nutrition, psychosocial, and health education assessments and interventions when indicated by identified risk factors as set forth in the DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal members. The risk assessment may be completed in person or virtually through a Telehealth visit, an early prenatal visit, once each trimester thereafter, and at the postpartum visit in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services.
1. Intimate partner violence (IPV) screening must be incorporated in the comprehensive risk assessment at the initial prenatal appointment – or at an alternative prenatal appointment – and when the risk assessment is repeated each trimester and during the postpartum assessment, ensuring safe disclosure without the presence of an intimate partner.
- I. Timely referrals to specialists, in accordance with CalOptima Health Policies CC.1700: Standards of Accessibility and Timely Access and GG.1600: Access and Availability Standards. Appropriate high-risk pregnancy referrals may include obstetric specialists, maternal-fetal medicine, behavioral health services, care management, Enhanced Care Management, Community Supports, or other medically necessary services
- J. Offer information about participating in the California Prenatal Screening (CA PNS) Program to all pregnant members who engage in care before twenty-one (21) weeks zero (0) days gestation for the detection of pregnancies at increased risk for carrying a fetus with chromosomal abnormalities, sex chromosome aneuploidies, or neural tube defects.
1. If a Member receives a positive or inconclusive CA PNS Program screening test result, then a regional CA PNS Program Coordinator will contact the prenatal Provider, who will provide a referral for necessary follow-up counseling and diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs)
 2. Documentation of consent/declination and referrals must be kept in the members medical record
 3. Ensure all newborns are screened for over eighty (80) serious but treatable genetic(passed down in families) and congenital (present at birth) disorders through the California Newborn Screening (CA NBS) Program, unless they opt out of screening for religious beliefs or practice which must be documented in the member's medical record. The CA NBS Program specimen collection must occur between twelve (12) and forty-eight (48) hours after birth, unless otherwise medically indicated.
- K. If the Member agrees to participate in CPSP the Contracted Provider shall provide prenatal and postpartum care in accordance with this Policy.
1. CalOptima Health shall not require Prior Authorization for CPSP. However, Prior Authorization is required if the amount of services exceeds the maximum frequency amounts as set forth in Title 22, California Code of Regulations (CCR) section 51504.

2. CalOptima Health shall provide CPSP to a pregnant Member for the duration of her pregnancy and through the postpartum period to include twelve (12) months (365 days) after the last day of pregnancy, or in accordance with the CPSP guidelines.

L. CHW services may be provided virtually through a telehealth visit with the Member's consent. Pregnant and postpartum members may receive up to six hours annually of Medi-Cal covered CHW services from a CHW operating under the supervision of an enrolled CHW Supervising Provider in accordance with DHCS APL 24-006: Community Health Worker Services Benefit, the Medi-Cal Provider Manual: CHW Preventive Services, and DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members.

M. A Contracted Provider shall complete a WIC referral form in accordance with WIC guidelines and document the date the Member was referred to WIC in the Member's Medical Record.

N. A Contracted Provider shall continue to provide obstetrical services to the Member in accordance with ACOG standards even if the Practitioner does not provide CPSP to the Member. These services include referrals to:

1. Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) testing, information, and counseling services; and
2. DHCS approved genetic diagnostic center, if necessary.

O. Monitoring and Reporting Requirements

1. On a quarterly basis, the Clinical Operations shall monitor and report on the availability of maternal health quality measures for Members. Aggregate reports shall include information on the following during the reporting period:

- a. Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment date or within forty-two (42) calendar days of enrollment in CalOptima Health.
- b. Timeliness of Postpartum Care: Percentage of deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) calendar days after delivery.
- c. The percentage of deliveries in which persons were screened for clinical depression using a standardized instrument during the prenatal and postpartum period.
- d. The percentage of deliveries in which persons received follow-up care within thirty (30) days of a positive depression screen finding.

2. CalOptima Health will review and evaluate birth outcome data annually using claims, authorization data, HEDIS performance, and other relevant data sources to guide Maternal Health program planning and enhancements.

3. The Clinical Operations Department shall submit the reports to the CalOptima Health Quality Improvement (QI) Committee for the evaluation and monitoring of Maternal Health Services, in accordance with the Quality Improvement (QI) Work Plan.

4. Delegated Health Networks and Providers shall comply with all applicable regulatory, contractual, state, and federal requirements related to maternal health, prenatal care, postpartum care and

associated members services. Compliance with these requirements is subject to monitoring, oversight, and audit at any time to ensure completion of all required activities, documentation, and standards of care.

5. CalOptima Health shall ensure Provider compliance with this Policy by conducting a record review in accordance with guidance from the DHCS and CalOptima Health Policy GG.1608: Full Scope Site Reviews.
6. Perinatal services out of compliance with DHCS standards for care and delivering programs and/or frequency of reporting requirements shall be subject to a Focused Review or require a Corrective Action Plan (CAP) if the issue remains unresolved, in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care
- B. American Rescue Plan Act (ARPA) of 2021
- C. California Department of Health Care Services (DHCS) Comprehensive Perinatal Services Program Provider Handbook
- D. California Welfare and Institutions Code, §14134.5
- E. CalOptima Health Contract for Health Care Services
- F. CalOptima Health Contract for Public Health Services with the Orange County Health Care Agency
- G. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- H. CalOptima Health Initial Outreach and Referral Process for Perinatal Support Services (PSS)
- I. CalOptima Health Policy CC.1400: Behavioral Health Services
- J. CalOptima Health Policy CC.1700: Standards of Accessibility and Timely Access
- K. CalOptima Health Policy GG.1109: CalOptima Health and Health Network Newborn and Prenatal Genetic Screening Services
- L. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
- M. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
- N. CalOptima Health Policy GG.1357: Population Health Management Transitional Care Services (TCS)
- O. CalOptima Health Policy GG.1600: Access and Availability Standards
- P. CalOptima Health Policy GG.1608: Full Scope Site Reviews
- Q. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
- R. CalOptima Health Policy GG.1704: Breastfeeding Promotion
- S. CalOptima Health Policy GG.1706: Child Abuse Report
- T. CalOptima Health Policy GG.1707: Doula Services
- U. CalOptima Health Policy GG.1900: Behavioral Health Services
- V. CalOptima Health Policy HH.2002: Sanctions
- W. CalOptima Health Policy HH.2005: Corrective Action Plan
- X. CalOptima Health Pregnancy Notification Report (PNR)
- Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/3/2023)
- Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
- AA. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008: Immunization Requirements (Supersedes APL 18-004 and 16-009)

- 1 BB. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-002: Medi-Cal Managed Care
2 Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 22-006)
3 CC. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-005: Maternity Services for
4 Pregnant and Postpartum Medi-Cal Members (Supersedes APLs 00-012, 18-022, and Policy Letters 98-
5 006, 98-010, and 12-003)
6 DD. Health and Safety Code, Division 105
7 EE. Title 22 California Code of Regulations (C.C.R.), §§ 51179 et seq., 51348 and 51504.
8 FF. Title 42 Code of Federal Regulations (C.F.R.), § 431.635(c)
9 GG. WIC Pediatric Referral
10 HH. WIC Referral for Postpartum/Breastfeeding Women
11 II. WIC Referral for Pregnant Women
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13 VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/04/2015	Department of Health Care Services (DHCS)	Approved as Submitted
08/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/02/2022	Department of Health Care Services (DHCS)	Approved as Submitted
07/29/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
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07/29/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR
10/17/2024	Department of Health Care Services (DHCS)	Approved as Submitted

15 VII. BOARD ACTION(S)

16 None to Date

17 VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	05/01/1999	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	05/01/2000	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	04/01/2007	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	01/01/2008	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	07/01/2015	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	09/01/2016	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	10/01/2017	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	10/01/2018	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2019	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	08/01/2021	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	04/01/2022	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	07/01/2022	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	07/01/2022	GG.1701	CalOptima Perinatal Support Services (PSS) Program	Medi-Cal
Revised	04/01/2023	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	08/01/2023	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	03/01/2024	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	08/01/2024	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	09/01/2025	GG.1701	CalOptima Health Perinatal Support Services (PSS) Program	Medi-Cal
Revised	TBD	GG.1701	Maternity Services for Pregnant and Postpartum Members	Covered California Medi-Cal

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IX. GLOSSARY

Term	Definition
Comprehensive Perinatal Services Program (CPSP)	Services as defined in Welfare and Institutions Code, Section 14134.5, and Title 22, California Code of Regulations, Sections 51179 et seq., 51348 and 51504. For CalOptima Health members, CPSP is incorporated into CalOptima Health's Perinatal Support Services.
Comprehensive Perinatal Service (CPSP) Provider	Any general practice physician, family practice physician, obstetrician-gynecologist, pediatrician, certified nurse midwife, family or pediatric nurse practitioner, alternative birth center, a group, any of whose members is one of the above-named physicians, or any preferred provider organization or clinic holding a valid and current Medi-Cal provider number and certified pursuant to the standards of this section.
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima Health, its contracted Health Networks or Physician Medical Groups.
Corrective Action Plan (CAP)	<u>Covered California:</u> <u>Medi-Cal:</u> 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.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024: Doula Services.
Focused Review	An audit that specifically targets areas of potential deficiency.
Freestanding Birth Center (FBC)	A health facility that is not a hospital where childbirth is planned to occur away from the pregnant woman's residence, and that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are in their scope of work as defined in 42 USC section 1396d(I)(3)(B).
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.
High-Risk Perinatal Member	Pregnant and postpartum individuals (up to 12 months after pregnancy ends) who are identified as needing intensive care management due to clinical, social, or behavioral health factors, hospitalizations, or a provider deems the member high-risk.
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	An individual enrolled in a CalOptima Health program.

Term	Definition
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.
Prior Authorization	<u>Covered California</u>: 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). <u>Medi-Cal</u>: A formal process requiring a Provider to obtain advanced approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal</u>: 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.
Transitional Care Services (TCS)	Care transitions are defined as a member transferring from one setting or level of care to another. Supporting members across all settings and delivery systems to ensure members are supported from discharge planning until successful connection to all needed services and supports.
Women, Infants, and Children (WIC)	The special supplemental nutrition program for women, infants, and children, authorized by section 17 of the Child Nutrition Act of 1966, 42 U.S.C. 1786.



Policy: GG.1704
Title: **Breastfeeding Promotion**
Department: Medical Case Management
Section: Case Management ~~Not Applicable~~

CEO Approval: /s/

Effective Date: 05/01/1999

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy describes the process by which CalOptima Health shall ensure that a pregnant Member receives breastfeeding information and services from CalOptima Health and its Health Networks.

II. POLICY

A. Breastfeeding is recognized as the preferred method of infant feeding by CalOptima Health and the American Academy of Pediatrics (AAP), American Dietetic Association, American College of Obstetrics and Gynecology, American Public Health Association, National Healthy Mothers Healthy Babies Coalition, and the U.S. Department of Health and Human Services “Healthy People 2030.”

~~B. CalOptima Health or a Health Network~~ Comprehensive perinatal services shall provide Perinatal Support Services (PSS) include obstetric, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy, and postpartum period to an eligible Member, include twelve (12) months (365 days) after the last day of pregnancy, or in accordance with the CPSP and ACOG guidelines and CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Maternity Services for Pregnant and Postpartum Members.

~~B.C.~~ CalOptima Health and delegated Health Networks shall cover lactation benefits and are prohibited from requiring Prior Authorization. Services (PSS) Program shall be available to prenatal and postpartum Members provided by Lactation Consultants or other qualified staff trained in lactation services. Contracted Providers must provide or refer members for breastfeeding services and cover benefits to postpartum by lactation consultants under the direction of a licensed Provider. Lactation visits are covered by Medi-Cal as in-person, home-based, and telehealth options.

~~C.D.~~ Breastfeeding Guidelines for Providers

1. CalOptima Health encourages Primary Care Providers (PCP) and Prenatal Care Providers to provide opportunities for learning about the advantages of breastfeeding through:
 - a. Educational materials; and

- 1 b. Referring the Member to CalOptima Health's programs that support perinatal
2 ~~Members~~Members' individual needs, such as but not limited to, Enhanced Care
3 Management (ECM) and maternal health education and classes.
4
- 5 2. CalOptima Health's or a Health Network's Prenatal Care Providers shall:
6
- 7 a. Assess a Member's interest and understanding of the importance of breastfeeding during the
8 first (1st) prenatal visit, each trimester, and during the postpartum period, when appropriate;
9
- 10 b. Provide a referral to the Women, Infants and Children (WIC) program for nutrition
11 education, breastfeeding support, healthy foods and to other community services.
12
- 13 c. Follow obstetrical standards of care to include:
14
- 15 i. Documentation of a complete breast exam; and
16
- 17 ii. Anticipatory guidance for any condition that could affect the Member's ability to
18 breastfeed.
19
- 20 d. Supply the member with breastfeeding educational materials and refer the Member to a
21 breastfeeding support and/or class ~~(available through CalOptima Health's Bright Steps~~
22 ~~Program and WIC);which must include;~~
23
- 24 i. Prenatal Period Lactation Education: Contracted Provider must provide nutrition and
25 health education assessments and interventions to pregnant Members that include
26 breastfeeding education and counseling. Information on the benefits of breastfeeding
27 and strategies to overcome common barriers to breastfeeding must be an integral part of
28 prenatal counseling.
29
- 30 ii. Postpartum Period Lactation Education: Contracted Providers Network shall support
31 postpartum breastfeeding, when appropriate. Support for breastfeeding includes health
32 education through the postpartum period, counseling, and the provision of Medically
33 Necessary interventions. This includes ensuring Members receive the necessary
34 breastfeeding counseling and support immediately after delivery.
35
- 36 e. Provide the Member with specific contact information for resources to call for assistance
37 with breastfeeding and information on how to know when the baby is getting enough milk.
38
- 39 f. Provide information on obtaining a breast pump and contracted Durable Medical Equipment
40 (DME) vendors to obtain a breast pump, if the Member is eligible; and
41
- 42 g. Provide information and, when required, submit a Prior Authorization for human ~~milk~~donor
43 breastmilk if the Member is eligible.
44
- 45 3. Hospitals that contract with CalOptima Health or a Health Network shall provide Members:
46
- 47 a. ~~Obstetrical care, in accordance with the guidance from the Baby-Friendly Hospital Initiative~~
48 ~~and/or the California Department of Public Health, "Providing Breastfeeding Support:~~
49 ~~Model Hospital Policy Recommendations" in promoting breastfeeding;~~
50

~~b.a.~~ Provide maternity care to make available breast-feeding consultation or alternatively, provide information to the mother on where to receive breast feeding information, in accordance with Health and Safety Code, Section 123365;

~~e.b. Adopt~~ Per state law, as of January 1, 2025, all general acute care hospitals and special hospitals in California must adopt the “Ten Steps to Successful Breastfeeding,” as adopted by Baby-Friendly USA, per the Baby-Friendly Hospital Initiative; (designation available for five years), or an alternate process adopted by a health care service plan that includes evidence-based policies and practices, and targeted outcomes, in accordance with Health and Safety Code, Section 123367; and or adopt the Model Hospital Policy Recommendations developed by CDPH.

c. By December 31, 2028, hospitals that have maternity -are required to they comply with this state law to be Baby-Friendly designated; or adopt the CDPH Model Hospital Policy Recommendations; or adopt an alternate process adopted by a health care service plan that includes evidence-based policies and practices and targeted outcomes, as identified in state law.

d. Discharge planning to include assessment of the need for post-discharge support including home visit by nurse or other qualified staff to support continuing breastfeeding at home, list of resources for support and assistance with breastfeeding, information on how to evaluate if ~~her~~the baby is getting enough milk, and referral for breastfeeding support group.

4. CalOptima Health’s pediatric providers shall:

a. Encourage Members to exclusively breastfeed for six (6) months and breastfeed with complementary foods (not formula) for at least twelve (12) months, pursuant to the AAP recommendations;

b. Follow specific criteria for assessment of the breastfeeding infant and early identification of breast-feeding problems, in accordance with the United Nations Children’s Fund (UNICEF) “Breastfeeding assessment tool”;

c. Refer the Member to a qualified consultant for evaluation before recommending stopping breastfeeding, or initiate supplementation with formula, if appropriate;

d. If the Member is recommended to stop breastfeeding, the Member shall be provided with instructions on how to obtain a breast pump through Medi-Cal or WIC;

e. If the baby has thrush, both the baby and mother shall receive treatment; and

f. If the baby needs hospitalization, arrangements for continued breastfeeding, or breast pumping, shall be coordinated.

5. Care during the postpartum period includes:

a. A postpartum visit between one (1) and twelve (12) weeks after delivery;

~~b. A postpartum review;~~

~~e.b.~~ An examination that includes obtaining a history, a physical exam, and evaluation of infant feeding;

~~d.c.~~ A maternal mental health screening of the Member, using evidence-based tools, must be completed during the postpartum period. If there is clinically significant depression, intervention may be needed and follow-up shall be within thirty (30) days; and

~~e.d.~~ Review or initiation of birth control methods should take into account the mother's lactation status.

D.E. Contraindications for breastfeeding

1. While breastfeeding has numerous health benefits, there are some situations in which it is not in the best interest of the infant. According to the AAP, among them are the infants suffering from galactosemia, if the Member is misusing substances, if the Member has untreated active tuberculosis, or if the ~~mother~~ Member is infected with the human immunodeficiency virus (HIV).
2. Although most Over-The-Counter medications are safe for breastfeeding women, the AAP lists medications that may require temporary interruption of breastfeeding. These include radioactive isotopes, antimetabolites, chemotherapy agents, and a small number of other medications. For additional information on drug interaction and breastfeeding refer to LactMed: <https://www.ncbi.nlm.nih.gov/books/NBK501922/>.

E. CalOptima Health and its Health Networks shall provide breastfeeding education and counseling to a Member as part of the Member's ~~PSS~~ maternal health services, in accordance with the provisions of this Policy, and the Department of Health Care Services (DHCS) ~~Medi-Cal Managed Care Division Policy Letter 98-010: All Plan Letter (APL) 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members~~ Breastfeeding Promotion.

F. CalOptima Health and its Health Networks shall refer an eligible Member to the Women, Infants, and Children (WIC) program, in accordance with CalOptima Health Policy GG.1701: ~~CalOptima Health Perinatal Support Services (PSS) Program~~ Maternity Services for Pregnant and Postpartum Members and DHCS APL 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members. CalOptima Health and its Health Networks shall coordinate breastfeeding promotion, education, and counseling services with WIC.

~~G. CalOptima Health shall participate in Orange County Perinatal Council meetings.~~

G. CalOptima Health, Health Networks and Contracted Providers shall ensure the ~~below requirements outlined in this section~~ requirements outlined in this section below ~~are to apply specifically to Members enrolled in Covered California and shall be implemented in accordance with applicable Covered California contractual, regulatory and program requirements.~~

1. Members shall have access to breastfeeding equipment and supplies, including standard breast pumps, as medically appropriate and consistent with Covered California and Affordable Care Act requirements for preventative services.
2. Delegated providers and networks are responsible for ensuring timely access to lactation counseling, breastfeeding support services, breast pumps and supplies.

III. PROCEDURE

- 1 A. A ~~Prenatal Care Contracted~~ Provider ~~or contracted PSS provider~~ shall provide breastfeeding
2 education to a Member during the Member's first (1st) obstetric visit and throughout her
3 participation in PSS, as necessary, and document such education in the Member's record.
4
- 5 B. CalOptima Health shall evaluate and approve all educational materials regarding breastfeeding prior
6 to dissemination to a Member. CalOptima Health shall ensure that breastfeeding education
7 materials:
8
- 9 1. Are culturally appropriate;
 - 10 2. Are written at the fifth (5th) grade education level, or below;
 - 11 3. Are not written or promoted by a baby formula manufacturer;
 - 12 4. Do not contain negative or contradictory information regarding breastfeeding;
 - 13 5. Are available in Threshold Languages; and
 - 14 6. Contain information regarding:
 - 15 a. Health benefits and economic advantages of breastfeeding including but not limited to the
16 potential reduction in risk for Type 2 diabetes, asthma, sudden infant death syndrome, and
17 childhood obesity;
 - 18 b. Maternal and infant nutrition, including the importance of exclusively breastfeeding the
19 infant for the first six (6) months of life, breastfeeding techniques, effective breastfeeding,
20 benefits of exclusively breastfeeding, understanding of and interventions for supporting
21 milk production, and signs of adequate feeding and nourishment;
 - 22 ~~c. Lactation management, including access to lactation education through the PSS program,~~
23 ~~appropriate breast pump when indicated, breastfeeding support group; and~~
 - 24 ~~d. Options for overcoming commonly perceived barriers to breastfeeding.~~
- 25
- 26 C. CalOptima Health, its Health Networks, or a contracted ~~PSS~~ provider shall provide postnatal
27 support to a breastfeeding Member through continued health education, counseling, and the
28 provision of medically necessary interventions.
29
- 30 D. A contracted ~~PSS~~ provider or Practitioner shall refer a Member for professional lactation
31 consultation services when necessary. The following persons may provide lactation consultation
32 services:
 - 33 1. A certified lactation consultant approved by CalOptima Health or a Health Network to provide
34 services;
 - 35 2. A PCP experienced in lactation consultation; or
 - 36 3. A knowledgeable Practitioner under the direction of a PCP.
- 37
- 38 E. A manual or electric breast pump is a covered benefit. (including wearable breast pumps that are
39 cordless or wireless) and breast pump supplies, as well as replacement breast pump supplies (which
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are considered lactation Durable Medical Equipment (DME) for breastfeeding Members as a Medical benefit.

1. A manual or electric breast pump may be obtained by written prescription or documentation by a pediatrician, obstetrician, or other licensed practitioner without Prior Authorization for approved pump model that is available through contracted DME vendors. Use of a hospital grade (multi-user) breast pump, which is an alternative to the purchase of a manual or electric breast pump, must meet the medical criteria and is available by rental only. Prior Authorization is not required for the initial three (3) months, but the vendor must submit Prior Authorization request for ongoing use beyond three (3) months. Prior Authorization for a hospital grade breast pump rental is limited to a total of twelve (12) months.
2. CalOptima Health and delegated Health Networks shall consider relevant clinical considerations, including but not limited to, a Member's medical condition(s) and diagnosis(es), physical or functional limitation(s) or special requirement(s), ability to achieve effective milk expression, and failure of lower-cost options. Contracted Providers must select DME to meet individual Members' medical needs.
3. Prior Authorization is not required for non-hospital grade breast pumps.
4. Contracted Providers and DME providers are encouraged to provide a breast pump at thirty-two (32) weeks zero (0) days gestation for pregnant Members or earlier for high-risk pregnancies.
5. Providers and contracted DME vendors shall not restrict Member choice to any one type of breast pump, model, or manufacturer.

E.F. A Member may be eligible for an electric breast pump if:

1. The infant is unable to nurse due to prematurity, respiratory, or cardiac problems affecting endurance, or other medical disorder;
2. The infant experiences problems with latching on to the Member's breast;
3. The Member or infant is hospitalized;
4. The Member is the mother of multiples;
5. The Member is on medication that contraindicates breastfeeding;
6. The Member experiences problems with ~~relactation;~~ or lactation;
7. The Member is returning to work or school and has difficulties maintaining milk supply with a manual breast pump; or

~~F. A manual or electric breast pump may be obtained by written prescription or documentation by a pediatrician, obstetrician, or other licensed practitioner without prior authorization for approved pump model that is available through contracted Durable Medical Equipment (DME) vendors when the charge for the pump does not exceed one hundred sixty four dollars (\$164.00) for purchase.~~

~~G. Use of a hospital grade (multi-user) breast pump, which is an alternative to the purchase of a manual or electric breast pump, must meet the medical criteria and is available by rental only. Prior authorization is not required for the initial three (3) months, but the vendor must submit prior~~

1 authorization request for ongoing use beyond three (3) months. Prior authorization for a hospital
2 grade breast pump rental is limited to a total of twelve (12) months.
3

4 8. Any other reason medically necessary to support breastfeeding, sustain milk supply or when
5 direct breastfeeding is difficult.
6

7 H.G. A Practitioner or contracted PSS provider shall refer a Member to WIC for breastfeeding
8 promotion, education, and counseling, in accordance with CalOptima Health Policy GG.1701:
9 CalOptima Health Perinatal Support Maternity Services (PSS) Program for Pregnant and Postpartum
10 Members and shall document the WIC referral in the Member's record.
11

12 I.H. CalOptima Health or a Member's Health Network shall authorize the provision of human milk donor
13 breastmilk for a Member if the Member is unable to breastfeed and the infant cannot tolerate any
14 form of formula or has a medical contraindication to the use of all formula types.
15

16 1. A Practitioner shall obtain prior authorization Prior Authorization from CalOptima Health or the
17 Member's Health Network for the provision of human milk donor breastmilk to the Member in
18 at least one (1) of the below situations:
19

20 a. A mother is unable to breast feed due to medical conditions;
21

22 b. The infant cannot tolerate or has medical contra-indications to using formulas including
23 elemental formulas;
24

25 c. The infant is born at a very low birthweight (less than 1500 g) and very premature (less than
26 thirty-two (32) weeks gestation);
27

28 d. Gastrointestinal anomaly, metabolic/digestive disorder, or recovery from intestinal surgery
29 when digestive needs require additional support;
30

31 e. Diagnosed with failure to thrive (not appropriately gaining weight/growing);
32

33 f. Formula intolerance, with documented feeding difficulty or weight loss;
34

35 g. Infant hypoglycemia (low blood sugar); congenital heart disease, pre or post organ
36 transplant;
37

38 h. Other serious health conditions when the use of banked donor milk is medically necessary
39 and supports the treatment and recovery of the infant; and/or
40

41 i. Mother's milk must be contraindicated, unavailable (due to medical or psychological
42 condition), or available but lacking in quantity or quality to meet the infant's needs.
43

44 2. CalOptima Health or the Member's Health Network shall adjudicate the Practitioner's
45 authorization request within the following timeframes:
46

47 a. Twenty-four (24) hours after receipt of an emergency request;
48

49 b. Forty-eight (48) hours after receipt of an urgent request; and
50

51 c. Five (5) business days after receipt of a standard request.
52

3. CalOptima Health or a Health Network shall coordinate the provision of human milk from a milk bank accredited by the Human Milk Banking Association of North America.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. American Academy of Pediatrics
B. American Dietetic Association
C. American College of Obstetrics and Gynecology
D. American Public Health Association
E. American Academy of Pediatrics (AAP) Policy Statement: Breastfeeding and the Use of Human Milk, American Academy of Pediatrics, July 2022, Volume 150, Issue 1
F. Breastfeeding: Maternal and Infant Aspects- Special Report, American College of Obstetricians and Gynecologists (ACOG) Clinical Review: Vol. 12, January-February 2007, Reaffirmed 2013
G. California Department of Public Health, Breastfeeding Initiative
H. California Department of Public Health, Comprehensive Perinatal Services Program
I. California Department of Public Health, "Breastfeeding Model Hospital Policy Recommendations, Fourth Edition, 2022."
J. CalOptima Health Contract for Health Care Services
K. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
L. CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Maternity Services (PSS) Program for Pregnant and Postpartum Members
M. Comprehensive Perinatal Services Program, Health Care Agency, County of Orange, CA
~~N. Department of Health Care Services (DHCS), Policy All Plan Letter (PL) 98-010: Breastfeeding Promotion (12/10/98)~~
~~O.N. Department of Health Care APL) 26-005: Maternity Services (DHCS), Policy Letter (PL) 12-003, for Pregnant and Postpartum Medi-Cal Members (Supersedes APLs 00-012, 18-022, and Policy Letter Letters 98-006, 98-010, 12-001 and 96-01: Obstetrical Care Perinatal Services (6/26/2003))~~
~~P.O. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, May 2024~~
~~Q.P. Health and Safety Code, §§ 123365-123367~~
~~R.Q. National Healthy Mothers Healthy Babies Coalition~~
~~S.R. National Committee for Quality Assurance, Volume 2, HEDIS Technical Specifications~~
~~T.S. Title 42, Code of Federal Regulations (C.F.R.), §431.635(c)~~
~~U.T. United Nations Children's Fund (UNICEF), Breastfeeding assessment tool. UNICEF, UK 2010~~
~~V.U. U.S. Department of Health and Human Services: Healthy People 2030.~~
~~W.V. U.S. Department of Health and Human Services: The Surgeon General's Call to Action to Support Breastfeeding- 2011, Washington, D.C.~~
~~X.W. Welfare and Institutions Code, Section 14134.55~~
~~Y.X. World Health Organization (WHO): Breastfeeding key to saving children's lives. WHO Report, WHO Geneva, 2010.~~

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/12/2014	Department of Health Care Services (DHCS)	Approved as Submitted
03/10/2016	Department of Health Care Services (DHCS)	Approved as Submitted

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VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/1999	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	04/01/2007	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	01/01/2008	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	10/01/2013	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	02/01/2016	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	02/01/2017	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
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Revised	03/01/2019	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	12/01/2020	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	08/01/2021	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
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<u>Revised</u>		<u>GG.1704</u>	<u>Breastfeeding Promotion</u>	<u>Covered California Medi-Cal</u>

IX. GLOSSARY

Term	Definition
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.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Member	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. An individual enrolled in a CalOptima Health program.
Perinatal Support Services (PSS)	Perinatal services as defined in the Contract for PSS.
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), Certified Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prenatal Care Provider	A Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Nurse Practitioner, Physician Assistant (PA), or Certified Nurse Midwife who provides prenatal care to a Member under the supervision of a licensed physician.
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.
Prior Authorization	<u>Covered California: 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).</u> <u>Medi-Cal:</u> A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.



Policy: GG.1704
Title: **Breastfeeding Promotion**
Department: Case Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 05/01/1999

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy describes the process by which CalOptima Health shall ensure that a pregnant Member receives breastfeeding information and services from CalOptima Health and its Health Networks.

II. POLICY

- A. Breastfeeding is recognized as the preferred method of infant feeding by CalOptima Health and the American Academy of Pediatrics (AAP), American Dietetic Association, American College of Obstetrics and Gynecology, American Public Health Association, National Healthy Mothers Healthy Babies Coalition, and the U.S. Department of Health and Human Services “Healthy People 2030.”
- B. Comprehensive perinatal services shall include obstetric, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy, and postpartum period to include twelve (12) months (365 days) after the last day of pregnancy, or in accordance with the CPSP and ACOG guidelines and CalOptima Health Policy GG.1701: Maternity Services for Pregnant and Postpartum Members.
- C. CalOptima Health and delegated Health Networks shall cover lactation benefits and are prohibited from requiring Prior Authorization. Services shall be available to prenatal and postpartum Members provided by Lactation Consultants or other qualified staff trained in lactation services. Contracted Providers must provide or refer members for breastfeeding services and cover benefits to postpartum by lactation consultants under the direction of a licensed Provider. Lactation visits are covered by Medi-Cal as in-person, home-based, and telehealth options.
- D. Breastfeeding Guidelines for Providers
 1. CalOptima Health encourages Primary Care Providers (PCP) and Prenatal Care Providers to provide opportunities for learning about the advantages of breastfeeding through:
 - a. Educational materials; and

- 1 b. Referring the Member to CalOptima Health's programs that support perinatal Members'
2 individual needs, such as but not limited to, Enhanced Care Management (ECM) and
3 maternal health education and classes.
- 4
- 5 2. CalOptima Health's or a Health Network's Prenatal Care Providers shall:
- 6
- 7 a. Assess a Member's interest and understanding of the importance of breastfeeding during the
8 first (1st) prenatal visit, each trimester, and during the postpartum period, when appropriate;
9
- 10 b. Provide a referral to the Women, Infants and Children (WIC) program for nutrition
11 education, breastfeeding support, healthy foods and to other community services.
- 12
- 13 c. Follow obstetrical standards of care to include:
- 14
- 15 i. Documentation of a complete breast exam; and
- 16
- 17 ii. Anticipatory guidance for any condition that could affect the Member's ability to
18 breastfeed.
- 19
- 20 d. Supply the member with breastfeeding educational materials and refer the Member to a
21 breastfeeding support and/or class which must include;
- 22
- 23 i. Prenatal Period Lactation Education: Contracted Provider must provide nutrition and
24 health education assessments and interventions to pregnant Members that include
25 breastfeeding education and counseling. Information on the benefits of breastfeeding
26 and strategies to overcome common barriers to breastfeeding must be an integral part of
27 prenatal counseling.
- 28
- 29 ii. Postpartum Period Lactation Education: Contracted Providers Network shall support
30 postpartum breastfeeding, when appropriate. Support for breastfeeding includes health
31 education through the postpartum period, counseling, and the provision of Medically
32 Necessary interventions. This includes ensuring Members receive the necessary
33 breastfeeding counseling and support immediately after delivery.
- 34
- 35 e. Provide the Member with specific contact information for resources to call for assistance
36 with breastfeeding and information on how to know when the baby is getting enough milk.
- 37
- 38 f. Provide information on obtaining a breast pump and contracted Durable Medical Equipment
39 (DME) vendors to obtain a breast pump, if the Member is eligible; and
- 40
- 41 g. Provide information and, when required, submit a Prior Authorization for human donor
42 breastmilk if the Member is eligible.
- 43
- 44 3. Hospitals that contract with CalOptima Health or a Health Network shall provide Members:
- 45
- 46 a. Provide maternity care to make available breast-feeding consultation or alternatively,
47 provide information to the mother on where to receive breast feeding information, in
48 accordance with Health and Safety Code, Section 123365;
- 49
- 50 b. Per state law, as of January 1, 2025, all general acute care hospitals and special hospitals in
51 California must adopt the "Ten Steps to Successful Breastfeeding," as adopted by Baby-
52 Friendly USA, per the Baby-Friendly Hospital Initiative (designation available for five

years), or an alternate process adopted by a health care service plan that includes evidence-based policies, practices, and targeted outcomes, or adopt the Model Hospital Policy Recommendations developed by CDPH.

- c. By December 31, 2028, hospitals that have maternity are required to they comply with this state law to be Baby-Friendly designated; or adopt the CDPH Model Hospital Policy Recommendations; or adopt an alternate process adopted by a health care service plan that includes evidence-based policies and practices and targeted outcomes, as identified in state law.
- d. Discharge planning to include assessment of the need for post-discharge support including home visit by nurse or other qualified staff to support continuing breastfeeding at home, list of resources for support and assistance with breastfeeding, information on how to evaluate if the baby is getting enough milk, and referral for breastfeeding support group.

4. CalOptima Health's pediatric providers shall:

- a. Encourage Members to exclusively breastfeed for six (6) months and breastfeed with complementary foods (not formula) for at least twelve (12) months, pursuant to the AAP recommendations;
- b. Follow specific criteria for assessment of the breastfeeding infant and early identification of breast-feeding problems, in accordance with the United Nations Children's Fund (UNICEF) "Breastfeeding assessment tool";
- c. Refer the Member to a qualified consultant for evaluation before recommending stopping breastfeeding, or initiate supplementation with formula, if appropriate;
- d. If the Member is recommended to stop breastfeeding, the Member shall be provided with instructions on how to obtain a breast pump through Medi-Cal or WIC;
- e. If the baby has thrush, both the baby and mother shall receive treatment; and
- f. If the baby needs hospitalization, arrangements for continued breastfeeding, or breast pumping, shall be coordinated.

5. Care during the postpartum period includes:

- a. A postpartum visit between one (1) and twelve (12) weeks after delivery;
- b. An examination that includes obtaining a history, a physical exam, and evaluation of infant feeding;
- c. A maternal mental health screening of the Member, using evidence-based tools, must be completed during the postpartum period. If there is clinically significant depression, intervention may be needed and follow-up shall be within thirty (30) days; and
- d. Review or initiation of birth control methods should take into account the mother's lactation status.

1 E. Contraindications for breastfeeding
2

- 3 1. While breastfeeding has numerous health benefits, there are some situations in which it is not in
4 the best interest of the infant. According to the AAP, among them are the infants suffering from
5 galactosemia, if the Member is misusing substances, if the Member has untreated active
6 tuberculosis, or if the Member is infected with the human immunodeficiency virus (HIV).
7
8 2. Although most Over-The-Counter medications are safe for breastfeeding women, the AAP lists
9 medications that may require temporary interruption of breastfeeding. These include radioactive
10 isotopes, antimetabolites, chemotherapy agents, and a small number of other medications. For
11 additional information on drug interaction and breastfeeding refer to LactMed:
12 <https://www.ncbi.nlm.nih.gov/books/NBK501922/>.
13

14 E. CalOptima Health and its Health Networks shall provide breastfeeding education and counseling to
15 a Member as part of the Member's maternal health services, in accordance with the provisions of
16 this Policy, and the Department of Health Care Services (DHCS) All Plan Letter (APL) 26-005:
17 Maternity Services for Pregnant and Postpartum Medi-Cal Members.
18

19 F. CalOptima Health and its Health Networks shall refer an eligible Member to the Women, Infants,
20 and Children (WIC) program, in accordance with CalOptima Health Policy GG.1701: Maternity
21 Services for Pregnant and Postpartum Members and DHCS APL 26-005: Maternity Services for
22 Pregnant and Postpartum Medi-Cal Members. CalOptima Health and its Health Networks shall
23 coordinate breastfeeding promotion, education, and counseling services with WIC.
24

25 G. CalOptima Health, Health Networks and Contracted Providers shall ensure the requirements
26 outlined in this section below are to apply specifically to Members enrolled in Covered California
27 and shall be implemented in accordance with applicable Covered California contractual, regulatory
28 and program requirements.
29

- 30 1. Members shall have access to breastfeeding equipment and supplies, including standard breast
31 pumps, as medically appropriate and consistent with Covered California and Affordable Care
32 Act requirements for preventative services.
33
34 2. Delegated providers and networks are responsible for ensuring timely access to lactation
35 counseling, breastfeeding support services, breast pumps and supplies.
36

37 **III. PROCEDURE**
38

39 A. A Contracted Provider shall provide breastfeeding education to a Member during the Member's first
40 (1st) obstetric visit and throughout her participation in PSS, as necessary, and document such
41 education in the Member's record.
42

43 B. CalOptima Health shall evaluate and approve all educational materials regarding breastfeeding prior
44 to dissemination to a Member. CalOptima Health shall ensure that breastfeeding education
45 materials:
46

- 47 1. Are culturally appropriate;
48
49 2. Are written at the fifth (5th) grade education level, or below;
50
51 3. Are not written or promoted by a baby formula manufacturer;
52

- 1 4. Do not contain negative or contradictory information regarding breastfeeding;
- 2
- 3 5. Are available in Threshold Languages; and
- 4
- 5 6. Contain information regarding:
- 6
- 7 a. Health benefits and economic advantages of breastfeeding including but not limited to the
- 8 potential reduction in risk for Type 2 diabetes, asthma, sudden infant death syndrome, and
- 9 childhood obesity;
- 10
- 11 b. Maternal and infant nutrition, including the importance of exclusively breastfeeding the
- 12 infant for the first six (6) months of life, breastfeeding techniques, effective breastfeeding,
- 13 benefits of exclusively breastfeeding, understanding of and interventions for supporting
- 14 milk production, and signs of adequate feeding and nourishment;
- 15
- 16 c. Options for overcoming commonly perceived barriers to breastfeeding.
- 17
- 18 C. CalOptima Health, its Health Networks, or a contracted provider shall provide postnatal support to a
- 19 breastfeeding Member through continued health education, counseling, and the provision of
- 20 medically necessary interventions.
- 21
- 22 D. A contracted provider or Practitioner shall refer a Member for professional lactation consultation
- 23 services when necessary. The following persons may provide lactation consultation services:
- 24
- 25 1. A certified lactation consultant approved by CalOptima Health or a Health Network to provide
- 26 services;
- 27
- 28 2. A PCP experienced in lactation consultation; or
- 29
- 30 3. A knowledgeable Practitioner under the direction of a PCP.
- 31
- 32 E. A manual or electric breast pump is a covered benefit. (including wearable breast pumps that are
- 33 cordless or wireless) and breast pump supplies, as well as replacement breast pump supplies (which
- 34 are considered lactation Durable Medical Equipment (DME) for breastfeeding Members as a Medi-
- 35 Cal benefit.
- 36
- 37 1. A manual or electric breast pump may be obtained by written prescription or documentation by
- 38 a pediatrician, obstetrician, or other licensed practitioner without Prior Authorization for
- 39 approved pump model that is available through contracted DME vendors. Use of a hospital
- 40 grade (multi-user) breast pump, which is an alternative to the purchase of a manual or electric
- 41 breast pump, must meet the medical criteria and is available by rental only. Prior Authorization
- 42 is not required for the initial three (3) months, but the vendor must submit Prior Authorization
- 43 request for ongoing use beyond three (3) months. Prior Authorization for a hospital grade breast
- 44 pump rental is limited to a total of twelve (12) months.
- 45
- 46 2. CalOptima Health and delegated Health Networks shall consider relevant clinical
- 47 considerations, including but not limited to, a Member's medical condition(s) and diagnosis(es),
- 48 physical or functional limitation(s) or special requirement(s), ability to achieve effective milk
- 49 expression, and failure of lower-cost options. Contracted Providers must select DME to meet
- 50 individual Members' medical needs.
- 51
- 52 3. Prior Authorization is not required for non-hospital grade breast pumps.

4. Contracted Providers and DME providers are encouraged to provide a breast pump at thirty-two (32) weeks zero (0) days gestation for pregnant Members or earlier for high-risk pregnancies.
 5. Providers and contracted DME vendors shall not restrict Member choice to any one type of breast pump, model, or manufacturer.
- F. A Member may be eligible for an electric breast pump if:
1. The infant is unable to nurse due to prematurity, respiratory, or cardiac problems affecting endurance, or other medical disorder;
 2. The infant experiences problems with latching on to the Member's breast;
 3. The Member or infant is hospitalized;
 4. The Member is the mother of multiples;
 5. The Member is on medication that contraindicates breastfeeding;
 6. The Member experiences problems with lactation;
 7. The Member is returning to work or school and has difficulties maintaining milk supply with a manual breast pump; or
 8. Any other reason medically necessary to support breastfeeding, sustain milk supply or when direct breastfeeding is difficult.
- G. A Practitioner or contracted PSS provider shall refer a Member to WIC for breastfeeding promotion, education, and counseling, in accordance with CalOptima Health Policy GG.1701: Maternity Services for Pregnant and Postpartum Members and shall document the WIC referral in the Member's record.
- H. CalOptima Health or a Member's Health Network shall authorize the provision of human donor breastmilk for a Member if the Member is unable to breastfeed and the infant cannot tolerate any form of formula or has a medical contraindication to the use of all formula types.
1. A Practitioner shall obtain Prior Authorization from CalOptima Health or the Member's Health Network for the provision of human donor breastmilk to the Member in at least one (1) of the below situations:
 - a. A mother is unable to breast feed due to medical conditions;
 - b. The infant cannot tolerate or has medical contra-indications to using formulas including elemental formulas;
 - c. The infant is born at a very low birthweight (less than 1500 g) and very premature (less than thirty-two (32) weeks gestation);
 - d. Gastrointestinal anomaly, metabolic/digestive disorder, or recovery from intestinal surgery when digestive needs require additional support;

- e. Diagnosed with failure to thrive (not appropriately gaining weight/growing);
 - f. Formula intolerance, with documented feeding difficulty or weight loss;
 - g. Infant hypoglycemia (low blood sugar); congenital heart disease, pre or post organ transplant;
 - h. Other serious health conditions when the use of banked donor milk is medically necessary and supports the treatment and recovery of the infant; and/or
 - i. Mother's milk must be contraindicated, unavailable (due to medical or psychological condition), or available but lacking in quantity or quality to meet the infant's needs.
2. CalOptima Health or the Member's Health Network shall adjudicate the Practitioner's authorization request within the following timeframes:
 - a. Twenty-four (24) hours after receipt of an emergency request;
 - b. Forty-eight (48) hours after receipt of an urgent request; and
 - c. Five (5) business days after receipt of a standard request.
 3. CalOptima Health or a Health Network shall coordinate the provision of human milk from a milk bank accredited by the Human Milk Banking Association of North America.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. American Academy of Pediatrics
- B. American Dietetic Association
- C. American College of Obstetrics and Gynecology
- D. American Public Health Association
- E. American Academy of Pediatrics (AAP) Policy Statement: Breastfeeding and the Use of Human Milk, July 2022, Volume 150, Issue 1
- F. Breastfeeding: Maternal and Infant Aspects- Special Report, American College of Obstetricians and Gynecologists (ACOG) Clinical Review: Vol. 12, January-February 2007, Reaffirmed 2013
- G. California Department of Public Health, Breastfeeding Initiative
- H. California Department of Public Health, Comprehensive Perinatal Services Program
- I. California Department of Public Health, Breastfeeding Model Hospital Policy Recommendations, Fourth Edition, 2022
- J. CalOptima Health Contract for Health Care Services
- K. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- L. CalOptima Health Policy GG.1701: Maternity Services for Pregnant and Postpartum Members
- M. Comprehensive Perinatal Services Program, Health Care Agency, County of Orange, CA
- N. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-005: Maternity Services for Pregnant and Postpartum Medi-Cal Members (Supersedes APLs 00-012, 18-022, and Policy Letters 98-006, 98-010, 12-003)
- O. Department of Health Care Services (DHCS) CalAIM: Population Health Management (PHM) Policy Guide, May 2024

- P. Health and Safety Code, §§ 123365-123367
 Q. National Healthy Mothers Healthy Babies Coalition
 R. National Committee for Quality Assurance, Volume 2, HEDIS Technical Specifications
 S. Title 42, Code of Federal Regulations (C.F.R.), §431.635(c)
 T. United Nations Children’s Fund (UNICEF), Breastfeeding assessment tool. UNICEF, UK 2010
 U. U.S. Department of Health and Human Services: Healthy People 2030
 V. U.S. Department of Health and Human Services: The Surgeon General’s Call to Action to Support Breastfeeding- 2011, Washington, D.C.
 W. Welfare and Institutions Code, Section 14134.55
 X. World Health Organization (WHO): Breastfeeding key to saving children’s lives. WHO Report, WHO Geneva, 2010.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/12/2014	Department of Health Care Services (DHCS)	Approved as Submitted
03/10/2016	Department of Health Care Services (DHCS)	Approved as Submitted
12/06/2023	Department of Health Care Services (DHCS)	File and Use
10/31/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/1999	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	04/01/2007	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	01/01/2008	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	10/01/2013	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	02/01/2016	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	02/01/2017	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	04/01/2018	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	03/01/2019	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	12/01/2020	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	08/01/2021	GG.1704	Breastfeeding Promotion	Medi-Cal OneCare Connect
Revised	07/01/2022	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	11/01/2023	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	10/01/2024	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised	09/01/2025	GG.1704	Breastfeeding Promotion	Medi-Cal
Revised		GG.1704	Breastfeeding Promotion	Covered California Medi-Cal

IX. GLOSSARY

Term	Definition
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.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity that contracts with CalOptima Health to provide Covered Services to Members.
Member	An individual enrolled in a CalOptima Health program.
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), Certified Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prenatal Care Provider	A Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Nurse Practitioner, Physician Assistant (PA), or Certified Nurse Midwife who provides prenatal care to a Member under the supervision of a licensed physician.
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.
Prior Authorization	<u>Covered California</u>: 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). <u>Medi-Cal</u>: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Threshold Languages	The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS.

Policy: GG.1707
 Title: **Doula Services**
 Department: ~~Medical Case~~ Management
 Section: ~~Case Management~~ Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2023

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy describes the eligibility criteria for CalOptima Health Doula ~~services~~ Services, identifies the qualifications for becoming a Provider of Doula providerServices, and details the provision of ~~CalOptima Health~~ Doula Services as a benefit.

II. POLICY

- A. CalOptima Health and Health Networks are required to provide Doula Services for prenatal, perinatal, and postpartum Members, regardless of pregnancy outcome, ~~when it recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law.~~
- B. CalOptima Health and Health Networks must provide Doulas with all necessary, initial, and ongoing training and resources regarding relevant services and processes, including any available services for prenatal, perinatal, and postpartum Members in accordance with CalOptima Health Policy EE.1103: Provider Network Training.
 1. Training must be provided initially when a Doula is enrolled with CalOptima Health and Health Networks, as well as on an ongoing basis.
 2. CalOptima Health and Health Networks are required to provide technical support in the administration of Doula Services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by ~~the Department of Health Care Services (DHCS)~~ applicable regulatory authorities.
 3. CalOptima Health shall support initial and ongoing capacity building for Doulas with CalOptima Health and Health Networks.
- C. For Medi-Cal only, Network Providers, ~~including those who will operate as Providers of Doula Services, rendering services to Medi-Cal Members~~ are required to enroll as Medi-Cal Providers when providing Medi-Cal-covered services, consistent with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment, or any superseding APL, ~~and CalOptima Health Policy GG.1650:~~

~~Credentialing, Re-credentialing of Practitioners, including enrolling in Medi-Cal~~ if there is a state-level enrollment pathway for them to do so.

D. All Network Providers, including those who will operate as Providers of Doula Services, must comply with applicable regulatory authorities and applicable requirements of CalOptima Health Policy GG.1650: Credentialing, Re-credentialing of Practitioners.

~~D.E.~~ CalOptima Health and Health Networks must ~~ensure~~have, and monitor their networks to ensure, a sufficient ~~Provider networks number of Providers are contracted~~ within their service areas, including Doulas, in accordance with ~~CalOptima Health Policy GG.1600: Access and Availability Standards~~applicable access and availability regulatory requirements, as applicable to the line of business.

1. CalOptima Health and Health Networks must make contracting available to both individual Doulas and Doula groups.
2. CalOptima Health and Health Networks must collaborate with their network hospitals/birthing centers to ensure there are no barriers to accessing these Providers when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).
3. CalOptima Health must coordinate for Out-of-Network (OON) access to Doula Services for Members if an In-Network Doula ~~provider~~Provider is not available for Medically Necessary Doula Services, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
4. If a Member desires to have a Doula during labor and delivery, CalOptima Health and its Health Networks, must work with their In-Network hospitals and birthing centers to allow the Doula, in addition to the support person(s), to be present.

~~E.F. Receiving For Medi-Cal only, receiving~~ Doula Services does not limit Medi-Cal Members from receiving ~~Perinatal Support Services (PSS)~~services through Comprehensive Perinatal Service Program (CPSP) providers or ~~Bright Steps in accordance with CalOptima Health Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program.~~

III. PROCEDURE

A. Doula Services can be provided virtually, in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services, or in person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers.

1. A Doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (*i.e.*, a Doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care).

a. The visit must be face-to-face, and the assistive or supportive service must be incidental to Doula Services provided during the prenatal or postpartum visit.

b. The Member cannot be billed for the assistive or supportive service.

B. The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a Network Provider with CalOptima Health.

1 C. Initial Recommendation and Self-Referral. A Member may self-refer to an in-Network contracted
2 Doula Services Provider to obtain Doula Services. In addition, a Member may obtain an initial
3 recommendation for Doula Services from a physician or licensed practitioner who has determined
4 that Doula Services are appropriate for the Member.

5
6 1. ~~An~~The initial recommendation ~~for Doula Services~~ can be provided through:

7
8 a. ~~A written recommendation in the Member's record;~~

9
10 b. ~~a.~~ A standing order for Doula Services by a CalOptima Health or a Health Network, physician
11 group or other group, or by a licensed Provider, ~~the Department of Health Care Services~~
12 ~~(DHCS); or;~~

13
14 i. ~~The standing recommendation issued by DHCS on November 1, 2023, fulfills this~~
15 ~~requirement until the time it is rescinded or modified.~~

16
17 e. ~~b.~~ A standard form, such as the ~~DHCS Medi-Cal Doula Services Recommendation or~~
18 CalOptima Health Recommendation Form(s), signed by a physician or other licensed
19 practitioner that a ~~member~~Member can provide to a Doula, ~~for Doula Services; or~~

20
21 c. ~~The~~For Medi-Cal only: In addition to the above methods for an initial recommendation
22 includes, Medi-Cal Members may also obtain an initial recommendation as follows:

23
24 i. A standard form, such as the DHCS Medi-Cal Doula Services Recommendation signed
25 by a physician or other licensed practitioner that a Member can provide to a Doula for
26 Doula Services; or

27
28 ii. A standing order from the DHCS; recommendation issued by DHCS on November 1,
29 2023, fulfills this requirement for Medi-Cal Members until the time it is rescinded or
30 modified.

31
32 2. Under the initial recommendation or self-referral, a Member may receive the following
33 authorizationsDoula Services:

34
35 a. One initial visit;

36
37 b. Up to eight (8) additional visits that can be provided in any combination of prenatal and
38 postpartum visits;

39
40 c. Support during labor and delivery (including labor and delivery resulting in a stillbirth),
41 abortion, or miscarriage; and

42
43 d. ~~Up to two (2) extended three (3) hour postpartum visits after the end of a pregnancy.~~

44
45 ~~d.~~ The extended three (3) hour postpartum visits provided after the end of pregnancy do not
46 require the Member to meet additional criteria or receive a separate recommendation.

47
48 E. ~~Covered Services not within the Doula Scope of License or Certification. If a Member requests or~~
49 ~~requires pregnancy-related services that are available through the applicable line of business and not~~
50 ~~within the Doula Services outlined in this policy, the~~ Doulas ~~should~~shall work with the Member's
51 Primary Care Provider (PCP) (if that information is available) or ~~work with~~ CalOptima Health or
52 Health Networks to refer the Member to a Network Provider ~~who is able to render the so that the~~
53 Member may obtain the appropriate covered service, if a Member requests or requires pregnancy-
54 related services that are available through Medi-Cal.

~~F.D.~~ These ~~Medi-Cal~~ services may include but are not limited to:

1. Behavioral health services;

~~b. Belly binding after cesarean section by clinical personnel;~~

~~3.2.~~ Clinical case coordination;

~~4.3.~~ Health care services related to pregnancy, birth, and the Postpartum Period;

~~5.4.~~ Childbirth education group classes;

~~a. Comprehensive health education including orientation, assessment, and planning
(Comprehensive Perinatal Services Program services);~~

~~g. Hypnotherapy (non-specialty mental health service);~~

~~8.5.~~ Lactation consulting, group classes, and supplies in accordance with CalOptima Health Policy
GG.1704: Breastfeeding Promotion;

~~9.6.~~ Nutrition services (assessment, counseling, and development of care plan); and

7. For Medi-Cal only:

a. Comprehensive health education including orientation, assessment, and planning
(Comprehensive Perinatal Services Program services);

j. Transportation; and

~~-b.~~ Medically appropriate Community Supports ~~services~~service.

~~F.E.~~ Eligibility Criteria for Doula Services

~~1. To be eligible for Doula Services, and be covered under Medi-Cal managed care, a the Member
must be eligible for Medi-Cal, enrolled in CalOptima Health, and may have recommendation
for Doula Services from a physician or other licensed practitioner of the healing arts.~~

~~2.1. Medi-Cal Eligibility Checks: Doulas must verify the Member's Medi-Cal enrollment for the
month of service and Doulas must contact the Member's Health Network or CalOptima Health
to verify eligibility.~~

~~1. Recommendation for Doula Services: A Member would meet the following criteria for a
recommendation for Doula Services if:~~

~~-a. The Member is pregnant, or was pregnant within the past year, (as further outlined in this
section) and would either benefit from Doula Services or they request requests Doula
Services. CalOptima Health and Health Networks will cover Doula Services can only be
provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion;
and within one year of the end of a Member's pregnancy.~~

- 1 2. Eligibility Checks: Doulas must verify the Member's enrollment for the month of service with
2 the applicable line of business. Doulas must contact the Member's Health Network or
3 CalOptima Health to verify eligibility.

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5 G.F. Documentation Requirements

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7 ~~1. Doula Services may provide an optional recommendation by a physician or other licensed~~
8 ~~practitioner of the healing arts acting within their scope of practice under state law prior to~~
9 ~~Doula services being provided.~~
10
11 1. The self-referral must be documented by the Doula in the Member's record.
12
13 2. Initial recommendations can be provided through approved methods as outlined in Section
14 III.C.1. of this Policy and must be documented in the Member's record.
15
16 3. Secondary recommendations are required for additional visits during the Postpartum period
17 beyond those listed in Section III.C.2.
18
19 a. A secondary recommendation must be established in a standard form signed by a physician
20 or other licensed practitioner that a Member can provide to a Doula for Doula Services. The
21 document must be maintained by the Doula for auditing. The following standard forms may
22 be used:
23
24 i. A CalOptima Health Recommendation form.
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26 ii. For Medi-Cal members, the DHCS Medi-Cal Doula Services Recommendation form
27 may be used instead of the CalOptima Health Recommendation form.
28
29 ~~a.b.~~ A recommendation for additional visits during the Postpartum Period cannot be established
30 by standing order or through self-referral.
31
32 ~~b.c.~~ The additional recommendation authorizes nine (9) or fewer additional postpartum visits.
33
34 4. CalOptima Health and Health Networks must ensure Doulas document the dates, time, and
35 duration of services provided to Members.
36
37 a. Documentation must also reflect information on the service provided and the length of time
38 spent with the Member that day.
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40 b. Documentation should be integrated into the Member's medical record and available for
41 encounter data reporting in accordance with CalOptima Health Policy EE.1111: Health
42 Network Encounter Reporting Requirements.
43
44 c. The Doula's National Provider Identifier (NPI) number should be included in the
45 documentation.
46
47 5. Documentation must be accessible to CalOptima Health and ~~DHCS~~ to applicable regulatory
48 authorities upon request.
49

50 H.G. Doula Requirements and Qualifications

- 51
52 1. All Doulas must be at least eighteen (18) years old, provide proof of an adult and infant
53 Cardiopulmonary Resuscitation (*i.e.*, CPR) certification from the American Red cross or

American Heart Association, and attest they have completed basic Health Insurance Portability and Accountability Act training.

2. A Doula must qualify by meeting either the training or experience pathway, as described below:

a. Training Pathway:

- i. Provide a certificate of Completion for a minimum of sixteen (16) hours of training which includes all of the following topics:
 - a) Lactation support;
 - b) Childbirth education;
 - c) Foundations on anatomy of pregnancy and childbirth;
 - d) Nonmedical comfort measures, prenatal support, and labor support techniques; and
 - e) Developing a community resource list.
- ii. Attest that they have provided support at a minimum of three (3) births.

b. Experience Pathway:

- i. All of the following:
 - a) Attest that they have provided services in the capacity of a Doula in either a paid or volunteer capacity for at least five (5) years. The five (5) years of experience in the capacity as a Doula must have occurred within the last seven (7) years.
 - b) Provide three (3) written client testimonial letters, or professional letters of recommendation from any of the following: a physician, licensed behavioral health Provider, nurse practitioner, nurse midwife, licensed midwife, enrolled Doula, or community-based organization. Letters must be written within the last seven (7) years. One (1) letter must be from either a licensed Provider, a community-based organization, or an enrolled Doula. "Enrolled Doula" means a Doula enrolled either through DHCS or through CalOptima Health or their delegated Health Networks.

c. Continuing Education:

- i. CalOptima Health and Health Networks must ensure Doulas complete three (3) hours of continuing education in maternal, perinatal, and/or infant care every three (3) years.
- ii. For Medi-Cal only, Doulas must maintain evidence of completed training to be made available to DHCS upon request, if providing services to Medi-Cal Members.

I.H. Non-Covered Doula Services:

1. Doula Services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.
2. The following services are not covered under ~~Medi-Cal or as~~ Doula Services:
 - a. Belly binding (traditional/ceremonial);

- b. Birthing ceremonies (*i.e.*, sealing, closing the bones, etc.);
 - c. Group classes on babywearing;
 - d. Massage (maternal or infant);
 - e. Photography;
 - f. Placenta encapsulation;
 - g. Shopping;
 - h. Vaginal steams; and
 - i. Yoga.
3. Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing Doula Services.

J.I. Billing and Payments

1. CalOptima Health, Health Networks, and any contracted group, must reimburse Doulas in compliance with applicable regulatory requirements, including the clean claims requirements and timeframes outlined in DHCS APL 23-020 ~~accordance with their~~ and the Knox-Keene Health Care Services Act and implementing regulations, Network Provider contract, and ~~in accordance with applicable~~ CalOptima Health Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible, and FF.1014: Payment for Covered Services Rendered to a Member Enrolled in a Health Network.
 - a. CalOptima Health and Health Networks are prohibited from establishing unreasonable or arbitrary barriers for accessing Doula Services.
 - b. For Medi-Cal only, a Medi-Cal Member may go to any Medi-Cal Provider of their choice for abortion services regardless of network affiliation. If a Member chooses to see an OON Provider for abortion services, CalOptima Health will reimburse for Covered Services in accordance with CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible.
2. Claims for Doula Services must be submitted with allowable current procedural terminology codes as outlined in the ~~Medi-Cal~~ Provider Manual.
 - a. Doulas cannot double bill, as applicable, for Doula Services that are duplicative to services that are reimbursed through other benefits.
3. All visits are limited to one per day, per Member. Only one (1) Doula can bill for a visit provided to the same Member on the same day, excluding labor and delivery. One (1) prenatal visit or one (1) postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different Doula.
4. The extended postpartum visits are billed in fifteen (15) minute increments, up to three (3) hours, up to two (2) visits per pregnancy per individual provided on separate days.

K.J. Monitoring

1. CalOptima Health and Health Networks must ensure that Providers of Doula Services ~~Providers~~ have a National Provider Identifier (NPI) and that these NPIs are entered in the 274 Network Provider File.
2. ~~DHCS~~ Applicable regulatory authorities will monitor CalOptima Health's ~~initial~~ implementation of Doula Services and requirements through existing data reporting mechanisms such as Encounter Data, Grievances and Appeals, and the 274 Network Provider File in accordance with CalOptima Health Policy AA.1270: Certification of Document and Data Submissions.
3. Health Networks and delegates must ensure all documentation and requirements are available to CalOptima Health and/or regulatory authorities upon request.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Policy AA.1270: Certification of Document and Data Submissions
- B. CalOptima Health Policy EE.1103: Provider Network Training
- C. CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements
- D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
- E. CalOptima Health Policy FF.1014: Payment for Covered Services Rendered to a Member Enrolled in a Health Network
- ~~F. CalOptima Health Policy GG.1600: Access and Availability Standards~~
- ~~G.F.~~ CalOptima Health Policy GG.1603: Medical Records Maintenance
- ~~H.G.~~ CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
- ~~I.H.~~ CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
- ~~J.I.~~ CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program
- ~~K.J.~~ CalOptima Health Policy GG.1704: Breastfeeding Promotion
- ~~L.K.~~ CalOptima Health Policy GG. 1539: Authorization for Out-of-Network and Out-of-Area Services
- ~~M.L.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004)
- ~~N.M.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-020: Requirements for Timely Payment of Claims (Revised 10/12/2023)
- ~~O.N.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031)
- O. Department of Managed Health Care (DMHC) All Plan Letter (APL) 26-005: Compliance with Assembly Bill 904, Maternal and Infant Health Equity Program
- P. Department of Health Care Services (DHCS) Medi-Cal Provider Manual – Doula Services
- Q. Title 42, Code of Federal Regulations (CFR), §440.130(c)
- R. Health and Safety Code § 1367.626

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/19/2023	Department of Health Care Services (DHCS)	Approved as Submitted

1 **VII. BOARD ACTION(S)**

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Date	Meeting
06/01/2023	Regular Meeting of the CalOptima Health Board of Directors

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4 **VIII. REVISION HISTORY**

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Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2023	GG.1707	Doula Services	Medi-Cal
Revised	11/01/2023	GG.1707	Doula Services	Medi-Cal
Revised	02/01/2024	GG.1707	Doula Services	Medi-Cal
Revised	09/01/2025	GG.1707	Doula Services	Medi-Cal
<u>Revised</u>		<u>GG.1707</u>	<u>Doula Services</u>	<u>Medi-Cal</u>

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For 20261001 BOD Review

1 IX. GLOSSARY

2

Term	Definition
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima Health's capitation rate and count toward the medical expense component of CalOptima Health's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima Health and the Member and must be approved by DHCS.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination) as set forth in DHCS APL 23-024, Doula Services.
Doula Services	Doula Services encompass health education, advocacy, and physical, emotional and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the Postpartum Period.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A 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. <u>An individual enrolled in a CalOptima Health program.</u>
Network Provider	<u>Covered California: Any provider as defined in HSC § 1345(i) located inside or outside of the Network Service Area of a designated network who meets all of the following criteria listed in Title 28 CCR § 1300.67.2.2(b)(10).</u> <u>Medi-Cal: Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal/CalOptima Health funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.</u>
Out-of-Network Provider	A Provider that does not participate in CalOptima Health's Network.
Postpartum Period	Doulas may provide services for up to twelve (12) months from the end of pregnancy. Beneficiaries are as long as the Member is eligible to receive full-scope Medi-Cal coverage for at least twelve (12) months after pregnancy.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. -A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	<u>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.</u> <u>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.</u>

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Policy: GG.1707
Title: **Doula Services**
Department: Case Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2023
Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy describes the eligibility criteria for CalOptima Health Doula Services, identifies the qualifications for becoming a Provider of Doula Services, and details the provision of Doula Services as a benefit.

II. POLICY

- A. CalOptima Health and Health Networks are required to provide Doula Services for prenatal, perinatal, and postpartum Members, regardless of pregnancy outcome.
- B. CalOptima Health and Health Networks must provide Doulas with all necessary, initial, and ongoing training and resources regarding relevant services and processes, including any available services for prenatal, perinatal, and postpartum Members in accordance with CalOptima Health Policy EE.1103: Provider Network Training.
 1. Training must be provided initially when a Doula is enrolled with CalOptima Health and Health Networks, as well as on an ongoing basis.
 2. CalOptima Health and Health Networks are required to provide technical support in the administration of Doula Services, ensuring accountability for all service requirements contained in the Contract, and any associated guidance issued by applicable regulatory authorities.
 3. CalOptima Health shall support initial and ongoing capacity building for Doulas with CalOptima Health and Health Networks.
- C. For Medi-Cal only, Network Providers rendering services to Medi-Cal Members are required to enroll as Medi-Cal Providers when providing Medi-Cal-covered services, consistent with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment, or any superseding APL, including enrolling in Medi-Cal if there is a state-level enrollment pathway for them to do so.
- D. All Network Providers, including those who will operate as Providers of Doula Services, must comply with applicable regulatory authorities and applicable requirements of CalOptima Health Policy GG.1650: Credentialing, Re-credentialing of Practitioners.

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- E. CalOptima Health and Health Networks must have, and monitor their networks to ensure, a sufficient number of Providers are contracted within their service areas, including Doulas, in accordance with applicable access and availability regulatory requirements, as applicable to the line of business.
 - 1. CalOptima Health and Health Networks must make contracting available to both individual Doulas and Doula groups.
 - 2. CalOptima Health and Health Networks must collaborate with their network hospitals/birthing centers to ensure there are no barriers to accessing these Providers when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits regardless of outcome (stillbirth, abortion, miscarriage, live birth).
 - 3. CalOptima Health must coordinate for Out-of-Network (OON) access to Doula Services for Members if an In-Network Doula Provider is not available for Medically Necessary Doula Services, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.
 - 4. If a Member desires to have a Doula during labor and delivery, CalOptima Health and its Health Networks, must work with their In-Network hospitals and birthing centers to allow the Doula, in addition to the support person(s), to be present.
 - F. For Medi-Cal only, receiving Doula Services does not limit Medi-Cal Members from receiving services through Comprehensive Perinatal Service Program (CPSP) providers.

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III. PROCEDURE

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- A. Doula Services can be provided virtually, in accordance with CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services, or in person with locations in any setting including, but not limited to, homes, office visits, hospitals, or alternative birth centers.
 - 1. A Doula is not prohibited from providing assistive or supportive services in the home during a prenatal or postpartum visit (*i.e.*, a Doula may help the postpartum person fold laundry while providing emotional support and offering advice on infant care).
 - a. The visit must be face-to-face, and the assistive or supportive service must be incidental to Doula Services provided during the prenatal or postpartum visit.
 - b. The Member cannot be billed for the assistive or supportive service.
 - B. The recommending physician or licensed practitioner does not need to be enrolled in Medi-Cal or be a Network Provider with CalOptima Health.
 - C. Initial Recommendation and Self-Referral. A Member may self-refer to an in-Network contracted Doula Services Provider to obtain Doula Services. In addition, a Member may obtain an initial recommendation for Doula Services from a physician or licensed practitioner who has determined that Doula Services are appropriate for the Member.
 - 1. The initial recommendation can be provided through:
 - a. A standing order for Doula Services by a CalOptima Health or a Health Network physician group or other group, or by a licensed Provider;

- 1 b. A standard form, such as the CalOptima Health Recommendation Form(s), signed by a
2 physician or other licensed practitioner that a Member can provide to a Doula for Doula
3 Services; or
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- 5 c. For Medi-Cal only: In addition to the above methods for an initial recommendation, Medi-
6 Cal Members may also obtain an initial recommendation as follows:
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- 8 i. A standard form, such as the DHCS Medi-Cal Doula Services Recommendation signed
9 by a physician or other licensed practitioner that a Member can provide to a Doula for
10 Doula Services; or
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- 12 ii. A standing order from the DHCS; recommendation issued by DHCS on November 1,
13 2023, fulfills this requirement for Medi-Cal Members until the time it is rescinded or
14 modified.
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- 16 2. Under the initial recommendation or self-referral, a Member may receive the following Doula
17 Services:
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- 19 a. One initial visit;
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- 21 b. Up to eight (8) additional visits that can be provided in any combination of prenatal and
22 postpartum visits;
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- 24 c. Support during labor and delivery (including labor and delivery resulting in a stillbirth),
25 abortion, or miscarriage; and
26
- 27 d. Up to two (2) extended three (3) hour postpartum visits after the end of a pregnancy. The
28 extended three (3) hour postpartum visits provided after the end of pregnancy do not require
29 the Member to meet additional criteria or receive a separate recommendation.
30
- 31 D. Covered Services not within the Doula Scope of License or Certification. If a Member requests or
32 requires pregnancy-related services that are available through the applicable line of business and not
33 within the Doula Services outlined in this policy, the Doulas shall work with the Member's Primary
34 Care Provider (PCP) (if that information is available) or CalOptima Health or Health Networks to
35 refer the Member to a Network Provider so that the Member may obtain the appropriate covered
36 service. These services may include but are not limited to:
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- 38 1. Behavioral health services;
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- 40 2. Clinical case coordination;
41
- 42 3. Health care services related to pregnancy, birth, and the Postpartum Period;
43
- 44 4. Childbirth education group classes;
45
- 46 5. Lactation consulting, group classes, and supplies in accordance with CalOptima Health Policy
47 GG.1704: Breastfeeding Promotion;
48
- 49 6. Nutrition services (assessment, counseling, and development of care plan); and
50
- 51 7. For Medi-Cal only:
52
- 53 a. Comprehensive health education including orientation, assessment, and planning
54 (Comprehensive Perinatal Services Program services);

- b. Medically appropriate Community Supports service.

E. Eligibility Criteria for Doula Services

1. To be eligible for Doula Services, the Member must be enrolled in CalOptima Health and meet the following criteria:
 - a. The Member is pregnant, or was pregnant within the past year (as further outlined in this section) and would either benefit from Doula Services or requests Doula Services. CalOptima Health and Health Networks will cover Doula Services provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a Member's pregnancy.
2. Eligibility Checks: Doulas must verify the Member's enrollment for the month of service with the applicable line of business. Doulas must contact the Member's Health Network or CalOptima Health to verify eligibility.

F. Documentation Requirements

1. The self-referral must be documented by the Doula in the Member's record.
2. Initial recommendations can be provided through approved methods as outlined in Section III.C.1. of this Policy and must be documented in the Member's record.
3. Secondary recommendations are required for additional visits during the Postpartum period beyond those listed in Section III.C.2.
 - a. A secondary recommendation must be established in a standard form signed by a physician or other licensed practitioner that a Member can provide to a Doula for Doula Services. The document must be maintained by the Doula for auditing. The following standard forms may be used:
 - i. A CalOptima Health Recommendation form.
 - ii. For Medi-Cal members, the DHCS Medi-Cal Doula Services Recommendation form may be used instead of the CalOptima Health Recommendation form.
 - b. A recommendation for additional visits during the Postpartum Period cannot be established by standing order or through self-referral.
 - c. The additional recommendation authorizes nine (9) or fewer additional postpartum visits.
4. CalOptima Health and Health Networks must ensure Doulas document the dates, time, and duration of services provided to Members.
 - a. Documentation must also reflect information on the service provided and the length of time spent with the Member that day.
 - b. Documentation should be integrated into the Member's medical record and available for encounter data reporting in accordance with CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements.

- 1 c. The Doula's National Provider Identifier (NPI) number should be included in the
2 documentation.
3
- 4 5. Documentation must be accessible to CalOptima Health and to applicable regulatory authorities
5 upon request.
6
- 7 G. Doula Requirements and Qualifications
8
- 9 1. All Doulas must be at least eighteen (18) years old, provide proof of an adult and infant
10 Cardiopulmonary Resuscitation (*i.e.*, CPR) certification from the American Red cross or
11 American Heart Association, and attest they have completed basic Health Insurance Portability
12 and Accountability Act training.
13
- 14 2. A Doula must qualify by meeting either the training or experience pathway, as described below:
15
- 16 a. Training Pathway:
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- 18 i. Provide a certificate of Completion for a minimum of sixteen (16) hours of training
19 which includes all of the following topics:
20
- 21 a) Lactation support;
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- 23 b) Childbirth education;
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- 25 c) Foundations on anatomy of pregnancy and childbirth;
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- 27 d) Nonmedical comfort measures, prenatal support, and labor support techniques; and
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- 29 e) Developing a community resource list.
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- 31 ii. Attest that they have provided support at a minimum of three (3) births.
32
- 33 b. Experience Pathway:
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- 35 i. All of the following:
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- 37 a) Attest that they have provided services in the capacity of a Doula in either a paid or
38 volunteer capacity for at least five (5) years. The five (5) years of experience in the
39 capacity as a Doula must have occurred within the last seven (7) years.
40
- 41 b) Provide three (3) written client testimonial letters, or professional letters of
42 recommendation from any of the following: a physician, licensed behavioral health
43 Provider, nurse practitioner, nurse midwife, licensed midwife, enrolled Doula, or
44 community-based organization. Letters must be written within the last seven (7)
45 years. One (1) letter must be from either a licensed Provider, a community-based
46 organization, or an enrolled Doula. "Enrolled Doula" means a Doula enrolled either
47 through DHCS or through CalOptima Health or their delegated Health Networks.
48
- 49 c. Continuing Education:
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- 51 i. CalOptima Health and Health Networks must ensure Doulas complete three (3) hours of
52 continuing education in maternal, perinatal, and/or infant care every three (3) years.
53

- 1 ii. For Medi-Cal only, Doulas must maintain evidence of completed training to be made
2 available to DHCS upon request, if providing services to Medi-Cal Members.
3

4 H. Non-Covered Doula Services:
5

- 6 1. Doula Services do not include diagnosis of medical conditions, provision of medical advice, or
7 any type of clinical assessment, exam, or procedure.
8
9 2. The following services are not covered under Doula Services:
10
11 a. Belly binding (traditional/ceremonial);
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13 b. Birthing ceremonies (*i.e.*, sealing, closing the bones, etc.);
14
15 c. Group classes on babywearing;
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17 d. Massage (maternal or infant);
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19 e. Photography;
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21 f. Placenta encapsulation;
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23 g. Shopping;
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25 h. Vaginal steams; and
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27 i. Yoga.
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29 3. Doulas are not prohibited from teaching classes that are available at no cost to Members to
30 whom they are providing Doula Services.
31

32 I. Billing and Payments
33

- 34 1. CalOptima Health, Health Networks, and any contracted group, must reimburse Doulas in
35 compliance with applicable regulatory requirements, including the clean claims requirements
36 and timeframes outlined in DHCS APL 23-020 and the Knox-Keene Health Care Services Act
37 and implementing regulations, Network Provider contract, and applicable CalOptima Health
38 Policies FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima
39 Health is Financially Responsible, and FF.1014: Payment for Covered Services Rendered to a
40 Member Enrolled in a Health Network.
41
42 a. CalOptima Health and Health Networks are prohibited from establishing unreasonable or
43 arbitrary barriers for accessing Doula Services.
44
45 b. For Medi-Cal only, a Medi-Cal Member may go to any Medi-Cal Provider of their choice
46 for abortion services regardless of network affiliation. If a Member chooses to see an OON
47 Provider for abortion services, CalOptima Health will reimburse for Covered Services in
48 accordance with CalOptima Health Policy FF.1003: Payment for Covered Services
49 Rendered to a Member for which CalOptima Health is Financially Responsible.
50
51 2. Claims for Doula Services must be submitted with allowable current procedural terminology
52 codes as outlined in the Provider Manual.
53

a. Doulas cannot double bill, as applicable, for Doula Services that are duplicative to services that are reimbursed through other benefits.

3. All visits are limited to one per day, per Member. Only one (1) Doula can bill for a visit provided to the same Member on the same day, excluding labor and delivery. One (1) prenatal visit or one (1) postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different Doula.

4. The extended postpartum visits are billed in fifteen (15) minute increments, up to three (3) hours, up to two (2) visits per pregnancy per individual provided on separate days.

J. Monitoring

1. CalOptima Health and Health Networks must ensure that Providers of Doula Services have a National Provider Identifier (NPI) and that these NPIs are entered in the 274 Network Provider File.

2. Applicable regulatory authorities will monitor CalOptima Health's implementation of Doula Services and requirements through existing data reporting mechanisms such as Encounter Data, Grievances and Appeals, and the 274 Network Provider File in accordance with CalOptima Health Policy AA.1270: Certification of Document and Data Submissions.

3. Health Networks and delegates must ensure all documentation and requirements are available to CalOptima Health and/or regulatory authorities upon request.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Policy AA.1270: Certification of Document and Data Submissions
- B. CalOptima Health Policy EE.1103: Provider Network Training
- C. CalOptima Health Policy EE.1111: Health Network Encounter Reporting Requirements
- D. CalOptima Health Policy FF.1003: Payment for Covered Services Rendered to a Member for which CalOptima Health is Financially Responsible
- E. CalOptima Health Policy FF.1014: Payment for Covered Services Rendered to a Member Enrolled in a Health Network
- F. CalOptima Health Policy GG.1603: Medical Records Maintenance
- G. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
- H. CalOptima Health Policy GG.1665: Telehealth and Other Technology-Enabled Services
- I. CalOptima Health Policy GG.1701: CalOptima Health Perinatal Support Services (PSS) Program
- J. CalOptima Health Policy GG.1704: Breastfeeding Promotion
- K. CalOptima Health Policy GG. 1539: Authorization for Out-of-Network and Out-of-Area Services
- L. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment (Supersedes APL 19-004)
- M. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-020: Requirements for Timely Payment of Claims (Revised 10/12/2023)
- N. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031)
- O. Department of Managed Health Care (DMHC) All Plan Letter (APL) 26-005: Compliance with Assembly Bill 904, Maternal and Infant Health Equity Program
- P. Department of Health Care Services (DHCS) Medi-Cal Provider Manual – Doula Services

Q. Title 42, Code of Federal Regulations (CFR), §440.130(c)
R. Health and Safety Code § 1367.626

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/19/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2023	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2023	GG.1707	Doula Services	Medi-Cal
Revised	11/01/2023	GG.1707	Doula Services	Medi-Cal
Revised	02/01/2024	GG.1707	Doula Services	Medi-Cal
Revised	09/01/2025	GG.1707	Doula Services	Medi-Cal
Revised		GG.1707	Doula Services	Medi-Cal

For 20261001 BOD

1 IX. GLOSSARY

2

Term	Definition
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima Health's capitation rate and count toward the medical expense component of CalOptima Health's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima Health and the Member and must be approved by DHCS.
Doula	A birth worker who provides health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during, and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth, and abortion (pregnancy termination).
Doula Services	Doula Services encompass health education, advocacy, and physical, emotional and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the Postpartum Period.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	An individual enrolled in a CalOptima Health program.
Network Provider	<u>Covered California</u> : Any provider as defined in HSC § 1345(i) located inside or outside of the Network Service Area of a designated network who meets all of the following criteria listed in Title 28 CCR § 1300.67.2.2(b)(10). <u>Medi-Cal</u> : Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives CalOptima Health funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Out-of-Network Provider	A Provider that does not participate in CalOptima Health's Network.
Postpartum Period	Doulas may provide services for up to twelve (12) months from the end of pregnancy as long as the Member is eligible.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	<u>Covered California</u> : A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal</u> : 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.

3

Policy: GG.1301
 Title: **Comprehensive Care Management Process**
 Department: ~~Medical Case~~ Management
 Section: ~~Case Management~~ Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2007

Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy defines the guidelines for Case Management of Members who are enrolled in the Medi-Cal or Covered California program, by CalOptima Health or a Health Network.

II. POLICY

- A. Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.
- B. The goal of Complex Case Management is to help a Member regain optimum health or improve functional capability, in the least restrictive setting and in a cost-effective manner.
 1. Complex Case Management is considered an opt-out program; all eligible Members have the right to participate or decline participation.
- C. Complex Case Management involves a comprehensive initial assessment and evaluation of a Member's condition, functional capacity, determination of available benefits, resources, cultural and linguistic needs, Social ~~Determinants~~ Drivers of Health, and barriers to care. This information is analyzed for meaning and evaluated in a Member-centric manner in order to develop and implement an Individual Care Plan (ICP) with prioritized Member goals that are followed up on and monitored for progress.
- D. CalOptima Health shall review and update its Case Management processes and resources to address Member needs, if necessary.
- ~~E. CalOptima Health or a Health Network shall ensure the provision of Case Management for CalOptima Health Members including~~ Complex Case Management may include Children and Youth with Special Health Care Needs (CYSHCN) and those eligible with the California Children's Services (CCS) Program ~~in accordance with.~~

- 1 E.F. CCS Complex Care Management (CCM) enrolled members shall also follow CalOptima Health
2 Policy GG.1330: Case Management - California Children's Services/Whole-Child Model.
3
4 ~~F. CalOptima Health or a Health Network shall ensure the provision of Case Management services for~~
5 ~~Members approved for Private Duty Nursing Services in accordance with CalOptima Health Policy~~
6 ~~GG.1352: Private Duty Nursing Care Management.~~
7
8 ~~G. CalOptima Health or a Health Network shall ensure the provision of Case Management for CalOptima~~
9 ~~Health Members eligible for Enhanced Case Management in accordance with CalOptima Health Policy~~
10 ~~GG.1353: CalAIM Enhanced Care Management Service Delivery.~~
11
12 H.G. CalOptima Health or a Health Network shall ensure Members enrolled in Complex Care
13 Management (CCM) are provided Basic Population Health Management in accordance with CalOptima
14 Health Policy GG.1667: CalAIM Population Health Management Program.
15
16 ~~I. CalOptima Health or a Health Network shall ensure training and notification requirements for~~
17 ~~Child Welfare Liaisons are in accordance with CalOptima Health Policy EE.1103: Provider Network~~
18 ~~Training.~~
19
20 ~~J.H. CalOptima Health shall coordinate~~ Continuity of Care coordination for CCM enrolled members in
21 accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into
22 CalOptima Health Services.
23
24 I. For Covered California (CCA), all functions addressed in this policy are 100% delegated to the Health
25 Network. The Health Network is responsible for complying with all requirements outlined in this
26 policy.
27

28 **III. PROCEDURE**

- 29
30 A. CalOptima Health and a Health Network shall identify Members for Complex Case Management
31 utilizing the following data sources if available:
32
33 1. Claims or encounter data;
34
35 2. Hospital or discharge data;
36
37 3. Pharmacy data;
38
39 4. Health information form;
40
41 5. Data collected through the utilization management (UM) process;
42
43 ~~6. Data supplied by purchasers, such as the Breast and Cervical Cancer Treatment Program;~~
44
45 ~~7.6.~~ Data supplied by Member or caregiver; and
46
47 ~~8.7.~~ Data supplied by Practitioners.
48
49 8. Risk Stratification and Segmentation (RSS)
50
51 9. Health Risk/Needs Assessment
52

1 B. CalOptima Health or a Health Network shall assess and provide Complex Case Management, as
2 appropriate, to the following Members:

3
4 1. A Member who is high-risk, defined as:

5
6 a. A Member who has a medically complex condition, including the most frequently managed
7 conditions; or

8
9 b. High risk groups, that may include, but are not limited to:

10
11 i. Spinal Injuries;

12
13 ii. Transplants;

14
15 iii. Cancer;

16
17 iv. Serious Trauma;

18
19 v. AIDS;

20
21 vi. Multiple chronic illnesses; and

22
23 vii. Chronic illnesses that result in high utilization.

24
25 2. A Member who has a complex social situation that affects the medical management of the
26 Member's care;

27
28 3. A Member who requires an extensive use of resources; or

29
30 4. A Member who has an illness or condition that is severe, and the level of management necessary is
31 very intensive.

32
33 C. CalOptima Health or a Health Network may provide a Member with Care Coordination Case
34 Management, to include an assessment and creation of a care plan, if the Member does not ~~qualify~~
35 ~~for enrollment in~~ Complex Case Management ~~but would benefit from care management support in~~
36 ~~accordance with GG.1324: Care Management and~~ Coordination ~~Case Management shall~~
37 ~~include:~~ Process.

38
39 ~~1. Assistance with access to care issues;~~

40
41 ~~2. Health and disease specific education;~~

42
43 ~~3. Referral to resources; and~~

44
45 ~~4. Coordination of care with all Providers.~~

46
47 D. A Member may be referred to Complex Case Management through:

48
49 1. Medical Management program referral;

50
51 2. Discharge planner referral;

52
53 3. UM referral;

1
2 4. Member ~~self-referral~~

3
4 5. Member's authorized representative/family referral

5
6 4.6. or caregiver referral;

7
8 5.7. Practitioner referral;

9
10 6.8. Community agency;

11
12 9. Customer Service referral

13
14 7.10. Health Network referral;

15
16 11. Long-term Services and Supports referral (Medi-Cal Only)

17
18 12. Disease Management Program

19
20 8.13. CalOptima Health shall communicate and provide details on the eligibility criteria and process for
21 referral for case management through the following:

- 22
23 a. Member newsletter;
- 24
25 b. Provider communications, including but not limited to, the Provider newsletter; and
- 26
27 c. Other materials or forums, as appropriate.

28
29 9.14. CalOptima Health or a Health Network may receive referrals by electronic transmission,
30 telephone, or written correspondence.

31
32 E. The Complex Case Management process shall include, but not be limited to:

- 33
34 1. Standardized mechanisms to systematically identify a high-risk Member;
- 35
36 2. Access to Case Management by ensuring multiple avenues for referrals;
- 37
38 3. Process to inform an eligible Member of the right to decline participation in, or disenroll from, Case
39 Management programs and services offered by CalOptima Health or a Health Network;
- 40
41 4. Complex Case Management system;
- 42
43 5. Documented Case Management process;
- 44
45 6. Initial assessment;
- 46
47 7. Process for providing ongoing Case Management;
- 48
49 8. Coordination of care to ensure provision of all Medically Necessary services;
- 50
51 9. Coordination of Targeted Case Management (TCM) to ensure provision of Medically Necessary
52 services;
- 53

10. Coordination of carve-out services;
11. Coordination of PDN nursing in accordance with CalOptima Health Policy GG.1352: Private Duty Nursing Care Management; (Medi-Cal Only), if applicable;
12. Coordination of services, both within and outside CalOptima Health's Service Area;
13. Coordination of Long Term Services ~~And~~ and Supports (LTSS) (Medi-Cal Only);
14. Coordination of behavioral health services;
15. Process for evaluating satisfaction with the Case Management program;
16. Process for measuring the effectiveness of Case Management; and
17. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI) Department.

F. Member Outreach

1. When a referral source is a Health Risk Assessment (HRA) or Health Needs Assessment (HNA), CalOptima Health or a Health Network shall contact the Member to obtain consent for ~~Care Coordination~~, Complex ~~Care~~ Case Management, complete initial assessment, and development of an ICP within thirty (30) days of HRA or HNA collection date or posting-date for returned mailed HRA or HNA.
2. When referral source is not an HRA or HNA ~~as outlined in section III.F.1~~ ~~for Care Coordination Case Management or Complex Case Management~~, CalOptima Health or a Health Network shall:
 - a. Contact the Member to obtain consent for ~~Care Coordination Case Management or~~ Complex Case Management services within two (2) business days for an urgent referral or within seven (7) business days from referral date;
 - b. Begin an initial assessment for the Member within thirty (30) calendar days of identification and complete within sixty (60) calendar days of identification; and
 - c. Develop an ICP within thirty (30) calendar days of assessment.

G. Initial Member Assessment

1. CalOptima Health or a Health Network shall conduct a Member's initial assessment and evaluation in the following manner:
 - a. Telephone interviews with the Member, the Member's Authorized Representative, or Member's family in accordance with CalOptima Health privacy and security policies for use and disclosure of health information, and in consultation with the Member. If the Member is unable to participate in the assessment, it may be completed by professionals on the care team, with assistance from the Member's family or caregiver;
 - b. Consultation with the Member's PCP, specialist physician, or support staff, as needed;

- 1 c. Review of Medical Records by a case manager, as needed;
- 2
- 3 d. Consultation with CalOptima Health's or Health Networks' staff, as needed; or
- 4
- 5 e. Consultation with a community agency, as needed.
- 6
- 7 2. CalOptima Health or a Health Network shall include the following in a Member's initial assessment
- 8 and evaluation for Complex Case Management. CalOptima Health or a Health Network will
- 9 document conclusions for each factor individually or in combination and the reasons for not
- 10 addressing any specified factor (e.g., life-planning in pediatric cases).
- 11
- 12 a. Member's current health status, specific to identified health conditions and likely co-
- 13 morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with
- 14 diabetes), and Member's self-reported health status. Information on the event or diagnosis that
- 15 led to the Member's eligibility for Case Management, and current medications, including
- 16 schedules and dosages.
- 17
- 18 b. Documentation of clinical history including:
- 19
- 20 i. Dates;
- 21
- 22 ii. Disease onset;
- 23
- 24 iii. Past hospitalizations and major procedures, including surgery;
- 25
- 26 iv. Significant past illnesses and treatment history;
- 27
- 28 v. Relevant past medications related to the Member's condition; and
- 29
- 30 vi. This factor does not require evaluation.
- 31
- 32 c. Assessment of Activities of Daily Living (ADL) related to, at a minimum, bathing, dressing,
- 33 going to the toilet, transferring, feeding and continence. Documentation will reflect reason and
- 34 type of assistance needed. If the Member needs no assistance with any ADLs, the case notes
- 35 reflect this (e.g., "Member is fully independent with ADLs.").
- 36
- 37 d. Evaluation of the Member's behavioral health status, including cognitive functioning, and the
- 38 ability to communicate, understand instructions, and process information about their illness as
- 39 well as the presence of any mental health conditions ~~or~~ and substance use disorders.
- 40
- 41 e. Assessment of Social ~~Determinants~~ Drivers of Health that may affect Members' ability to
- 42 adhere to the care plan such as: economic and social status, social support networks, education
- 43 and literacy, employment, physical and social environment, personal health practices, coping
- 44 skills, beliefs and concerns about the condition, or treatment, perceived barriers to meeting
- 45 treatment requirements, or access to transportation and financial barriers to obtaining treatment
- 46 (as Social ~~Determinants~~ Drivers of Health are a combination of influences, assessment must
- 47 include more than one (1) Social ~~Determinant~~ Drivers of Health).
- 48
- 49 f. Assessment of the Member's life planning activities, such as wills, living wills, or advance
- 50 directives, health care powers of attorney, and Physician Orders of Life-Sustaining Treatment
- 51 (POLST). CalOptima Health or a Health Network shall provide information on life
- 52 planning/advance directives to the Member if these preferences are not on record, as

appropriate. In the event that life planning activities are not appropriate, documentation must be present to support why the organization did not assess life planning activities.

- g. Evaluation of cultural and linguistic needs, preferences, or limitations that may make it difficult to effectively communicate or for the Member to accept specific treatments. This evaluation shall include consideration of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- h. Evaluation of visual and hearing needs, preferences, limitations, and characteristics that make it difficult for the care team to communicate effectively with the Member.
- i. Evaluation for adequacy of caregiver resources, such as family or other support person involvement and role in decision making about the care plan. Documentation describes the resources in place, whether they are sufficient for the Member's needs, and notes specific gaps to address, if applicable.
- j. Evaluation of available ~~benefits, including the Member's eligibility and pertinent financial information regarding benefits~~ health benefits a Member may be eligible for. The assessment shall include a determination of whether the resources available to the Member are adequate to fulfill the treatment plan. Assessed benefits may include:
 - i. Benefits covered by CalOptima Health, the Health Network, and by Providers;
 - ii. Services carved-out by CalOptima Health and Health Networks, including but not limited to dental services; and
 - iii. Services that supplement those the organization has been contracted to Provider (i.e., Community Mental Health).
- k. Evaluation of community resources, ~~including includes~~ assessments of potential eligibility ~~for and availability of~~ community resources that supplement CalOptima Health resources, ~~such as which must include when applicable~~ community mental health, transportation, wellness organizations, support groups, palliative care programs, nutritional support, and other national and community resources that would be helpful and appropriate to the Member's treatment plan-, including, but not limited to:

~~3. Identification and referral of a Member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:~~

~~i. Children and Youth with Special Health Care Needs (CYSHCN);~~

~~i. Members may be identified upon enrollment and periodically based on available data.~~

~~ii. Members may be identified through referrals.~~

~~iii. Members and their representatives will be educated on available resources.~~

~~iv. Members will be encouraged to participate in the Case Management process, including Whole Child Model Members, as described in Section III.E. of this policy.~~

~~ii.i.~~ California Children's Services (CCS), as described in CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program;

~~iii-ii.~~ Genetically Handicapped Persons Program (GHPP);

~~iv-iii.~~ Local Educational Agency (LEA);

~~v-iv.~~ Regional Center of Orange County (RCOC);

~~vi-v.~~ Section 1915(c) Home and Community-Based Services (HCBS) Waivers: (Medi-Cal Only);

a) AIDS Medi-Cal Waiver Program;

b) Assisted Living Waiver (ALW);

c) Home and Community-Based Alternatives (HCBA) Waiver;

d) Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver; and

e) Self-Determination Program.

~~vii-vi.~~ Specialty Mental Health Services, ~~as described in CalOptima Health Policy GG.1103: Specialty Mental Health Services;~~

~~viii-vii.~~ OCHCA Tuberculosis Program (Direct Observation Therapy); and

~~ix-viii.~~ Long Term Services and Supports: (Medi-Cal only), including:

a) Community-Based Adult Services (CBAS);

b) In-Home Support Services (IHSS); and

c) Multipurpose Senior Services Program (MSSP).

H. Individual Care Plan (ICP) and Ongoing Management

1. A case manager shall develop, implement, and modify a Member's ICP in collaboration with the Member, Member's Provider, and/or their caregiver. A case manager may also develop, implement, and modify a Member's ICP in collaboration with the Member's Authorized Representative, members of the interdisciplinary care team, and/or specialist, when feasible.

2. CalOptima Health and a Health Network shall include the following elements in a Member's ICP:

a. Prioritized goals using high/low, numeric rank or other similar designation that consider the Member's and caregiver's goals, preferences, and desired level of involvement in the Case Management plan, and shall include goals personalized to meet a Member's specific needs, including the following:

i. Timeframe for re-evaluation of goals;

ii. Resources to be utilized, including the appropriate level of care;

iii. Planning for Continuity of Care, including transition of care and transfers between settings;

- iv. Collaborative approaches to be used, including level of family participation; and
- v. Evaluating Member's personal preferences.
- b. Identification of barriers to meeting goals, or compliance with ICP:
- i. Barrier analysis shall include issues such as language, or literacy, ~~lack of or~~ limited access to reliable transportation, ~~lack of~~ understanding of condition, ~~lack of~~ motivation, financial or health insurance issues, cultural or spiritual beliefs, hearing, or vision, limits, and psychological impairment.
- ii. Documentation of assessment for barriers, even if none identified.
- c. Coordination of carved out services and referrals to appropriate community resources, agencies, and when applicable if benefits are exhausted, including but not limited to HCBS waivers.
- i. Members will be referred who have an identified need during assessment, noted from Member outreach, from data sources identified in Section III.A. of this policy will be referred; and
- ii. Case Manager will follow-up with the Member to ensure access, address barriers to access, and review alternatives to address care needs.
- d. Facilitation of Member referrals to appropriate resources, including referrals to health organizations, and a follow-up process to determine whether Members act on those referrals, including referrals to external resources, including but not limited to HCBS waivers and whether there are barriers present.
- e. Supporting continued access to in-network Providers.
- f. Development of a schedule for follow-up and communication with a Member, which may include, but not be limited to, counseling, follow-up after referral to a Medical Management program, follow-up after referral to a health resource, and education self-management support.
- i. When and how a case manager will follow up with a Member after facilitating a referral to a health resource shall be documented. When follow-up is not appropriate, this determination shall be documented.
- ii. Documentation of the next scheduled ~~Member~~ contact with Member and contact method.
- g. Development and communication (e.g., orally or written) of a self-management plan that is acknowledged and agreed to by the Member ~~or caregiver~~. Self-management plans are actions the Member agrees to take to manage a condition or circumstance. Self-management plans are based on instructions or materials provided to Members or their caregivers. Member self-management plan of activities includes, but is not limited to:
- i. Maintaining a prescribed diet;
- ii. Charting daily readings (e.g., weight, blood sugar); or
- iii. Changing a wound dressing, as directed.

- 1 h. Assessment of progress towards meeting Case Management plans and goals and overcoming
2 barriers to care. The process includes reassessing and adjusting the care plans and its goals, as
3 needed.
4
- 5 ~~i. Planning for Continuity of Care or transition of care when benefit coverage ends. CalOptima~~
6 ~~Health or a Health Network shall:~~
7
- 8 ~~i. Identify transitioning Members who are receiving approved services, but whose benefit~~
9 ~~coverage will end while still needing Medically Necessary care;~~
10
- 11 ~~ii. Identify available community resources and alternative care; and~~
12
- 13 ~~iii. Notify and educate transitioning Members regarding alternative care and community~~
14 ~~resources.~~
15
- 16 ~~iv. Provide Continuity of Care for special populations as defined by DHCS and outlined below,~~
17 ~~may provide continuity of care in accordance with Section II.H. of this policy:~~
18
- 19 ~~a) Adults and children with authorizations to receive Enhanced CalOptima Health Policy~~
20 ~~GG.1324: Care Management (ECM) services;~~
21
- 22 ~~b) Adults and children with authorizations to receive Community Supports;~~
23
- 24 ~~c) Adults and children receiving Complex Care Management;~~
25
- 26 ~~d) Enrolled in 1915(c) waiver programs;~~
27
- 28 ~~e) Receiving in-home supportive services (IHSS);~~
29
- 30 ~~f) Children and youth enrolled in California Children's Services (CCS)/CCS Whole Child~~
31 ~~Model;~~
32
- 33 ~~g) Children and youth receiving foster care, and former foster youth through age nineteen~~
34 ~~to twenty-five (19-25);~~
35
- 36 ~~h) In active treatment for the following chronic communicable diseases: HIV/AIDS,~~
37 ~~tuberculosis, and hepatitis B and C;~~
38
- 39 ~~i) Taking immunosuppressive medications, immunomodulators, and biologics;~~
40
- 41 ~~j) Receiving treatment for end-stage renal disease (ESRD);~~
42
- 43 ~~k) Living with an intellectual or developmental disability (I/DD) diagnosis;~~
44
- 45 ~~l) Living with a dementia diagnosis;~~
46
- 47 ~~m) In the transplant evaluation process, on any waitlist to receive a transplant, undergoing~~
48 ~~a transplant, or received a transplant in the previous twelve (12) months;~~
49
- 50 ~~n) Pregnant or postpartum (within twelve (12) months of the end of a pregnancy or~~
51 ~~maternal mental health diagnosis);~~
52
- 53 ~~o) Receiving specialty mental health services (adults, youth, and children);~~

- ~~p) Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality;~~
- ~~q) Receiving hospice care for the duration of the terminal illness;~~
- ~~r) Receiving home health;~~
- ~~s) Residing in Skilled Nursing Facilities (SNF);~~
- ~~t) Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD);~~
- ~~u) Receiving hospital inpatient care for the duration of the acute condition;~~
- ~~1) CalOptima Health or a Health Network shall contact the PCP, when informed by prior MCP, of Members receiving care management who are known to be receiving inpatient care.~~
- ~~2) CalOptima Health shall inform the receiving MCP of Members known to be receiving inpatient care by December 22, 2023, and refresh daily through January 9, 2024.~~
- ~~v) Post discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023;~~
- ~~w) Newly prescribed DME (within thirty (30) days of January 1, 2024) and~~
- ~~j.i. Members receiving Community-Based Adult Services and Coordination Process.~~

3. A Member shall actively participate in the development of his or her ICP, in accordance with his or her individual physical and psychosocial capabilities.
4. CalOptima Health or a Health Network shall re-evaluate and update a Member's ICP based on the Member's level of complexity and clinical needs.
5. CalOptima Health and a Health Network shall terminate Complex Case Management for a Member when the Member:
- Achieves ICP goals;
 - Becomes ineligible for Case Management; or
 - Declines Case Management.

~~4. Targeted Case Management (TCM)~~

- ~~1. CalOptima Health and a Health Network may identify and refer a Member to the Orange County Health Care Agency (HCA) for Department of Health Care Services (DHCS) TCM services when the individual falls into one of the identified target populations below, has undergone a CalOptima Health Case Management assessment, and meets criteria outlined below:~~
- ~~a. Women, infants, children and young adults to age twenty one (21).~~

~~b. Pregnant women.~~

~~c. Persons with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome.~~

~~d. Persons with reportable communicable disease.~~

~~e. Persons who are Technology Dependent.~~

~~f. Persons with multiple diagnoses who require services from multiple health/social service providers.~~

~~g. Persons who are Medically Fragile.~~

~~2. CalOptima Health and a Health Network may identify and refer a Member for DHCS TCM services when the Member meets one (1) or more of the following criteria:~~

~~a. Member is determined to be in need of care management services for non-medical needs.~~

~~b. CalOptima Health has determined that the Member has demonstrated an on-going inability to access CalOptima Health services.~~

~~c. CalOptima Health has determined that Member would benefit from TCM face-to-face case management.~~

~~d. CalOptima Health has concerns that the Member has an inadequate support system for medical care.~~

~~e. CalOptima Health has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the CalOptima Health care plan.~~

~~3. A Member who is referred and not accepted for TCM shall receive comparable Case Management services through CalOptima Health or a Health Network.~~

~~4. CalOptima Health shall ensure there is no duplication of services for Members who are enrolled in both TCM through the HCA, and complex or care coordination case management through CalOptima Health or a Health Network.~~

~~a. Data feed from DHCS when available is evaluated routinely to identify Members open in TCM and Case Management.~~

~~b. For Members who have both a TCM case manager and a CalOptima Health or Health Network case manager, the case managers shall share information vital to the care of the Member, which may include information, assessments, and care plans, and ensure non-duplication of services.~~

~~J.I.~~ CalOptima Health and a Health Network shall utilize Case Management systems that support Case Management, by utilizing the following methods:

1. Evidence-based clinical guidelines or algorithms are embedded in the medical management system to guide case managers through assessment and ongoing management of a Member;

2. A documentation process that includes automated notation of the staff members' identification, date, and time of entry, and records each action or interaction with the Member, Primary Care Practitioner (PCP), or Provider; and
3. Automated prompts and reminders for next steps and follow-up care and contact scheduled with the Member.

~~K.J.~~ CalOptima Health and a Health Network shall provide Practitioners and Members, or caregivers as applicable, with written information about the Case Management program, to include the following:

1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a Member;
2. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and
3. Information regarding how CalOptima Health or the Health Network works with a Member in the Case Management program.

~~L.K.~~ On an annual basis, CalOptima Health shall evaluate Member satisfaction with CalOptima Health's or the Health Network's Case Management program. CalOptima Health shall use the following to evaluate Member satisfaction:

1. Obtaining Member feedback;
2. Analyzing Member complaints and inquiries; and
3. Reporting the results of the evaluation to the ~~Quality Assurance~~ Member Experience Committee (~~QAC~~).

~~M.L.~~ CalOptima Health shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

~~A. ZeOmega Evidence Based Clinical Protocols (2025)~~
Not Applicable

V. REFERENCES

- A. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
- B. CalOptima Health Contract for Health Care Services
- C. Coordination and Provision of Public Health Care Services Contract
- ~~D. CalOptima Health Policy EE.1103: Provider Network Training~~
- ~~E.D.~~ CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program
- ~~F.E.~~ CalOptima Health Policy GG.1103: Specialty Mental Health Services 1324: Care Management and Coordination Process
- ~~G.F.~~ CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
- ~~H.G.~~ CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
- ~~I.H.~~ CalOptima Health Policy GG.1352: Private Duty Nursing Care Management
- ~~J. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery~~

~~K.I.~~ CalOptima Health Policy GG.1619: Delegation Oversight
~~L.J.~~ CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
~~K.~~ Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
~~M.L.~~ Case Management Society of America (CMSA): Standards of Practice for Case Management
~~N.~~ National Committee for Quality Assurance (NCQA) 2024 PHM 5: Complex Case Management
~~O.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing
~~P.M.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Service Whole Child Model Program (Supersedes APL 23-034)
~~N.~~ Department of Health Care Services (DHCS) All Plan Letter (APL) 26-009: Private Duty Nursing Supersedes APL 20-012)
~~O.~~ National Committee for Quality Assurance (NCQA) 2026 PHM 5: Complex Case Management
~~Q.A.~~ Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
~~R.P.~~ Title 22, California Code of Regulations (C.C.R.), §51185
~~S.Q.~~ ZeomegaZeOmega Evidence-Based Clinical Protocol; Revised 03/18/25

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency	Response
09/09/2015	Department of Health Care Services (DHCS)	NR-90
01/20/2016	Department of Health Care Services (DHCS)	NR-90
06/21/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/07/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/14/2023	Department of Health Care Services (DHCS)	Approved as Submitted
<u>09/09/2026</u>	<u>Department of Health Care Services (DHCS)</u>	<u>File and Use</u>

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
06/03/2021	Regular Meeting of the CalOptima Board of Directors [Ratification]

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2010	GG.1301	Case Management Process	Medi-Cal
Revised	08/01/2011	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2013	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2014	GG.1301	Complex Case Management Process	Medi-Cal
Revised	04/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	11/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	10/01/2016	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	07/01/2017	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	05/01/2021	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	06/01/2022	GG.1301	Comprehensive Case Management Process	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2023	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	07/01/2023	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	04/01/2025	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	07/01/2025	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	09/01/2025	GG.1301	Comprehensive Care Management Process	Medi-Cal
<u>Revised</u>		<u>GG.1301</u>	<u>Comprehensive Care Management Process</u>	<u>Medi-Cal</u>

For 20261001 BOD Review Only

1 IX. GLOSSARY

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Term	Definition
Authorized Representative	<u>Covered California: 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 DHCS State Fair Hearings, 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.</u> <u>Medi-Cal:</u> Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Care Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Children and Youth with Special Health Care Needs (CYSHCN)	Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CYSHCN shall comply with the requirements of 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).

Term	Definition
Complex Care/Case Management	An approach to care management that meets differing needs of high-and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements
Complex Case Management Eligible Member	Members who are at high-risk; defined as having medically complex conditions that may include the following but is not limited to: 1. Spinal Injuries; 2. Transplants; 3. Cancer; 4. Serious trauma; 5. AIDS; 6. Multiple chronic illnesses; or 7. Chronic illnesses that result in high utilization. Or Member with a medical condition and a complex social situation that affects the medical management of the Member's care and requires extensive use of resources.
Continuity of Care	<u>Covered California: Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship.</u> <u>Medi-Cal:</u> Services provided to a Member rendered by an out-of-network provider with whom the Member has a pre-existing provider relationship.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
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 Risk Assessment (HRA)	An assessment required for Seniors and Persons with Disabilities. Effective January 1, 2023, HRA assessment requirements for Seniors and Persons with Disabilities are simplified, while specific member protections are kept in place.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Medically Fragile Persons (Targeted Case Management Services program)	Those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.
Medically Necessary or Medical Necessity	<u>Covered California: Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship.</u> <u>Medi-Cal:</u> Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically

Term	Definition
	Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medical Management Program	For purposes of this policy: Disease management programs, utilization management programs, health information lines or similar programs that can identify needs for Complex Case Management and are managed by organization or vendor staff.
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. <u>An individual enrolled in a CalOptima Health program.</u>
Primary Care Practitioner/Physician (PCP)	<u>A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a primary care physician or non-physician medical practitioner.</u> <u>Medi-Cal:</u> A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Private Duty Nursing (PDN)	An Early Periodic Screening, Detection, and Treatment (EPSDT) Supplemental Service that includes Medically Necessary services provided to Members who require continuous in-home nursing care.
Provider	<u>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.</u> <u>Medi-Cal:</u> 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.

Term	Definition
Service Area	<u>Covered California: The county or counties in which CalOptima Health is approved to operate under the terms of its QHP Contract with the Exchange. The service area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by the Exchange for CalOptima Health to operate under the terms of the QHP Contract.</u> <u>Medi-Cal:</u> The county or counties that CalOptima Health is approved to operate in under the terms of the DHCS contract. Currently, this covers Orange County, California.
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. Also known as Health Related Social Needs.
Targeted Case Management	Services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

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Policy: GG.1301
Title: **Comprehensive Care Management Process**
Department: Case Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2007
Revised Date:

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy defines the guidelines for Case Management of Members who are enrolled in the Medi-Cal or Covered California program, by CalOptima Health or a Health Network.

II. POLICY

- A. Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.
- B. The goal of Complex Case Management is to help a Member regain optimum health or improve functional capability, in the least restrictive setting and in a cost-effective manner.
1. Complex Case Management is considered an opt-out program; all eligible Members have the right to participate or decline participation.
- C. Complex Case Management involves a comprehensive initial assessment and evaluation of a Member's condition, functional capacity, determination of available benefits, resources, cultural and linguistic needs, Social Drivers of Health, and barriers to care. This information is analyzed for meaning and evaluated in a Member-centric manner in order to develop and implement an Individual Care Plan (ICP) with prioritized Member goals that are followed up on and monitored for progress.
- D. CalOptima Health shall review and update its Case Management processes and resources to address Member needs, if necessary.
- E. Complex Case Management may include Children and Youth with Special Health Care Needs (CYSHCN) and those eligible with the California Children's Services (CCS) Program.
- F. CCS Complex Care Management (CCM) enrolled members shall also follow CalOptima Health Policy GG.1330: Case Management - California Children's Services/Whole-Child Model.

- 1 G. CalOptima Health or a Health Network shall ensure Members enrolled in Complex Care Management
2 (CCM) are provided Basic Population Health Management in accordance with CalOptima Health Policy
3 GG.1667: CalAIM Population Health Management Program.
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5 H. CalOptima Health or a Health Network shall ensure Continuity of Care coordination for CCM enrolled
6 members in accordance with CalOptima Health Policy GG.1325: Continuity of Care for Members
7 Transitioning into CalOptima Health Services.
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9 I. For Covered California (CCA), all functions addressed in this policy are 100% delegated to the Health
10 Network. The Health Network is responsible for complying with all requirements outlined in this
11 policy.
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13 **III. PROCEDURE**

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15 A. CalOptima Health and a Health Network shall identify Members for Complex Case Management
16 utilizing the following data sources if available:
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18 1. Claims or encounter data;
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20 2. Hospital or discharge data;
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22 3. Pharmacy data;
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24 4. Health information form;
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26 5. Data collected through the utilization management (UM) process;
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28 6. Data supplied by Member or caregiver; and
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30 7. Data supplied by Practitioners.
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32 8. Risk Stratification and Segmentation (RSS)
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34 9. Health Risk/Needs Assessment
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36 B. CalOptima Health or a Health Network shall assess and provide Complex Case Management, as
37 appropriate, to the following Members:
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39 1. A Member who is high-risk, defined as:
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41 a. A Member who has a medically complex condition, including the most frequently managed
42 conditions; or
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44 b. High risk groups, that may include, but are not limited to:
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46 i. Spinal Injuries;
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48 ii. Transplants;
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50 iii. Cancer;
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52 iv. Serious Trauma;
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- v. AIDS;
 - vi. Multiple chronic illnesses; and
 - vii. Chronic illnesses that result in high utilization.
2. A Member who has a complex social situation that affects the medical management of the Member's care;
 3. A Member who requires an extensive use of resources; or
 4. A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.
- C. CalOptima Health or a Health Network may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not enroll in Complex Case Management in accordance with GG.1324: Care Management and Coordination Process.
- D. A Member may be referred to Complex Case Management through:
1. Medical Management program referral;
 2. Discharge planner referral;
 3. UM referral;
 4. Member self-referral
 5. Member's authorized representative/family referral
 6. or caregiver referral;
 7. Practitioner referral;
 8. Community agency;
 9. Customer Service referral
 10. Health Network referral;
 11. Long-term Services and Supports referral (Medi-Cal Only)
 12. Disease Management Program
 13. CalOptima Health shall communicate and provide details on the eligibility criteria and process for referral for case management through the following:
 - a. Member newsletter;
 - b. Provider communications, including but not limited to, the Provider newsletter; and
 - c. Other materials or forums, as appropriate.

1 14. CalOptima Health or a Health Network may receive referrals by electronic transmission, telephone,
2 or written correspondence.
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4 E. The Complex Case Management process shall include, but not be limited to:
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- 6 1. Standardized mechanisms to systematically identify a high-risk Member;
- 7 2. Access to Case Management by ensuring multiple avenues for referrals;
- 8 3. Process to inform an eligible Member of the right to decline participation in, or disenroll from, Case
9 Management programs and services offered by CalOptima Health or a Health Network;
- 10 4. Complex Case Management system;
- 11 5. Documented Case Management process;
- 12 6. Initial assessment;
- 13 7. Process for providing ongoing Case Management;
- 14 8. Coordination of care to ensure provision of all Medically Necessary services;
- 15 9. Coordination of Targeted Case Management (TCM) to ensure provision of Medically Necessary
16 services;
- 17 10. Coordination of carve-out services;
- 18 11. Coordination of PDN nursing in accordance with CalOptima Health Policy GG.1352: Private Duty
19 Nursing Care Management (Medi-Cal Only), if applicable;
- 20 12. Coordination of services, both within and outside CalOptima Health's Service Area;
- 21 13. Coordination of Long Term Services and Supports (LTSS) (Medi-Cal Only);
- 22 14. Coordination of behavioral health services;
- 23 15. Process for evaluating satisfaction with the Case Management program;
- 24 16. Process for measuring the effectiveness of Case Management; and
- 25 17. Mechanism for identification and referral of quality of care issues to the Quality Improvement (QI)
26 Department.

27 F. Member Outreach
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- 29 1. When a referral source is a Health Risk Assessment (HRA) or Health Needs Assessment (HNA),
30 CalOptima Health or a Health Network shall contact the Member to obtain consent for Complex
31 Case Management, complete initial assessment, and development of an ICP within thirty (30) days
32 of HRA or HNA collection date or posting-date for returned mailed HRA or HNA.
- 33 2. When referral source is not an HRA or HNA outlined in section III.F.1 CalOptima Health or a
34 Health Network shall:
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- a. Contact the Member to obtain consent for Complex Case Management services within two (2) business days for an urgent referral or within seven (7) business days from referral date;
- b. Begin an initial assessment for the Member within thirty (30) calendar days of identification and complete within sixty (60) calendar days of identification; and
- c. Develop an ICP within thirty (30) calendar days of assessment.

G. Initial Member Assessment

1. CalOptima Health or a Health Network shall conduct a Member's initial assessment and evaluation in the following manner:
 - a. Telephone interviews with the Member, the Member's Authorized Representative, or Member's family in accordance with CalOptima Health privacy and security policies for use and disclosure of health information, and in consultation with the Member. If the Member is unable to participate in the assessment, it may be completed by professionals on the care team, with assistance from the Member's family or caregiver.
 - b. Consultation with the Member's PCP, specialist physician, or support staff, as needed;
 - c. Review of Medical Records by a case manager, as needed;
 - d. Consultation with CalOptima Health's or Health Networks' staff, as needed; or
 - e. Consultation with a community agency, as needed.
2. CalOptima Health or a Health Network shall include the following in a Member's initial assessment and evaluation for Complex Case Management. CalOptima Health or a Health Network will document conclusions for each factor individually or in combination and the reasons for not addressing any specified factor (e.g., life-planning in pediatric cases).
 - a. Member's current health status, specific to identified health conditions and likely co-morbidities and their status; (e.g., high-risk pregnancy and heart disease, for Members with diabetes), and Member's self-reported health status. Information on the event or diagnosis that led to the Member's eligibility for Case Management, and current medications, including schedules and dosages.
 - b. Documentation of clinical history including:
 - i. Dates;
 - ii. Disease onset;
 - iii. Past hospitalizations and major procedures, including surgery;
 - iv. Significant past illnesses and treatment history;
 - v. Relevant past medications related to the Member's condition; and
 - vi. This factor does not require evaluation.

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- c. Assessment of Activities of Daily Living (ADL) related to, at a minimum, bathing, dressing, going to the toilet, transferring, feeding and continence. Documentation will reflect reason and type of assistance needed. If the Member needs no assistance with any ADLs, the case notes reflect this (e.g., “Member is fully independent with ADLs.”).
 - d. Evaluation of the Member’s behavioral health status, including cognitive functioning, and the ability to communicate, understand instructions, and process information about their illness as well as the presence of any mental health conditions and substance use disorders.
 - e. Assessment of Social Drivers of Health that may affect Members’ ability to adhere to the care plan such as: economic and social status, social support networks, education and literacy, employment, physical and social environment, personal health practices, coping skills, beliefs and concerns about the condition, or treatment, perceived barriers to meeting treatment requirements, or access to transportation and financial barriers to obtaining treatment (as Social Drivers of Health are a combination of influences, assessment must include more than one (1) Social Drivers of Health).
 - f. Assessment of the Member’s life planning activities, such as wills, living wills, or advance directives, health care powers of attorney, and Physician Orders of Life-Sustaining Treatment (POLST). CalOptima Health or a Health Network shall provide information on life planning/advance directives to the Member if these preferences are not on record, as appropriate. In the event that life planning activities are not appropriate, documentation must be present to support why the organization did not assess life planning activities.
 - g. Evaluation of cultural and linguistic needs, preferences, or limitations that may make it difficult to effectively communicate or for the Member to accept specific treatments. This evaluation shall include consideration of cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
 - h. Evaluation of visual and hearing needs, preferences, limitations, and characteristics that make it difficult for the care team to communicate effectively with the Member.
 - i. Evaluation for adequacy of caregiver resources, such as family or other support person involvement and role in decision making about the care plan. Documentation describes the resources in place, whether they are sufficient for the Member’s needs, and notes specific gaps to address, if applicable.
 - j. Evaluation of available health benefits a Member may be eligible for. The assessment shall include a determination of whether the resources available to the Member are adequate to fulfill the treatment plan. Assessed benefits may include:
 - i. Benefits covered by CalOptima Health, the Health Network, and by Providers;
 - ii. Services carved-out by CalOptima Health and Health Networks, including but not limited to dental services; and
 - iii. Services that supplement those the organization has been contracted to Provider (i.e., Community Mental Health).
 - k. Evaluation of community resources includes assessments of potential eligibility and availability of community resources that supplement CalOptima Health resources, which must include when applicable community mental health, transportation, wellness organizations, support

groups, palliative care programs, nutritional support, and other national and community resources that would be helpful and appropriate to the Member's treatment plan, including, but not limited to:

- i. California Children's Services (CCS), as described in CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program;
- ii. Genetically Handicapped Persons Program (GHPP);
- iii. Local Educational Agency (LEA);
- iv. Regional Center of Orange County (RCOC);
- v. Section 1915(c) Home and Community-Based Services (HCBS) Waivers (Medi-Cal Only):
 - a) AIDS Medi-Cal Waiver Program;
 - b) Assisted Living Waiver (ALW);
 - c) Home and Community-Based Alternatives (HCBA) Waiver;
 - d) Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver; and
 - e) Self-Determination Program.
- vi. Specialty Mental Health Services,
- vii. OCHCA Tuberculosis Program (Direct Observation Therapy); and
- viii. Long Term Services and Supports (Medi-Cal only), including:
 - a) Community-Based Adult Services (CBAS);
 - b) In-Home Support Services (IHSS); and
 - c) Multipurpose Senior Services Program (MSSP).

H. Individual Care Plan (ICP) and Ongoing Management

1. A case manager shall develop, implement, and modify a Member's ICP in collaboration with the Member, Member's Provider, and/or their caregiver. A case manager may also develop, implement, and modify a Member's ICP in collaboration with the Member's Authorized Representative, members of the interdisciplinary care team, and/or specialist, when feasible.
2. CalOptima Health and a Health Network shall include the following elements in a Member's ICP:
 - a. Prioritized goals using high/low, numeric rank or other similar designation that consider the Member's and caregiver's goals, preferences, and desired level of involvement in the Case Management plan, and shall include goals personalized to meet a Member's specific needs, including the following:

- i. Timeframe for re-evaluation of goals;
 - ii. Resources to be utilized, including the appropriate level of care;
 - iii. Planning for Continuity of Care, including transition of care and transfers between settings;
 - iv. Collaborative approaches to be used, including level of family participation; and
 - v. Evaluating Member's personal preferences.
- b. Identification of barriers to meeting goals, or compliance with ICP:
- i. Barrier analysis shall include issues such as language, or literacy, limited access to reliable transportation, understanding of condition, motivation, financial or health insurance issues, cultural or spiritual beliefs, hearing, or vision, limits, and psychological impairment.
 - ii. Documentation of assessment for barriers, even if none identified.
- c. Coordination of carved out services and referrals to appropriate community resources, agencies, and when applicable if benefits are exhausted, including but not limited to HCBS waivers.
- i. Members will be referred who have an identified need during assessment, noted from Member outreach, from data sources identified in Section III.A. of this policy will be referred; and
 - ii. Case Manager will follow-up with the Member to ensure access, address barriers to access, and review alternatives to address care needs.
- d. Facilitation of Member referrals to appropriate resources, including referrals to health organizations, and a follow-up process to determine whether Members act on those referrals, including referrals to external resources, including but not limited to HCBS waivers and whether there are barriers present.
- e. Supporting continued access to in-network Providers.
- f. Development of a schedule for follow-up and communication with a Member, which may include, but not be limited to, counseling, follow-up after referral to a Medical Management program, follow-up after referral to a health resource, and education self-management support.
- i. When and how a case manager will follow up with a Member after facilitating a referral to a health resource shall be documented. When follow-up is not appropriate, this determination shall be documented.
 - ii. Documentation of the next scheduled contact with Member and contact method.
- g. Development and communication (e.g., orally or written) of a self-management plan that is acknowledged and agreed to by the Member or caregiver. Self-management plans are actions the Member agrees to take to manage a condition or circumstance. Self-management plans are based on instructions or materials provided to Members or their caregivers. Member self-management plan of activities includes, but is not limited to:
- i. Maintaining a prescribed diet;

- 1 ii. Charting daily readings (e.g., weight, blood sugar); or
- 2
- 3 iii. Changing a wound dressing, as directed.
- 4
- 5 h. Assessment of progress towards meeting Case Management plans and goals and overcoming
- 6 barriers to care. The process includes reassessing and adjusting the care plans and its goals, as
- 7 needed.
- 8
- 9 i. CalOptima Health or a Health Network may provide continuity of care in accordance with
- 10 CalOptima Health Policy GG.1324: Care Management and Coordination Process.
- 11
- 12 3. A Member shall actively participate in the development of his or her ICP, in accordance with his or
- 13 her individual physical and psychosocial capabilities.
- 14
- 15 4. CalOptima Health or a Health Network shall re-evaluate and update a Member's ICP based on the
- 16 Member's level of complexity and clinical needs.
- 17
- 18 5. CalOptima Health and a Health Network shall terminate Complex Case Management for a Member
- 19 when the Member:
- 20
- 21 a. Achieves ICP goals;
- 22
- 23 b. Becomes ineligible for Case Management; or
- 24
- 25 c. Declines Case Management.
- 26
- 27 I. CalOptima Health and a Health Network shall utilize Case Management systems that support Case
- 28 Management, by utilizing the following methods:
- 29
- 30 1. Evidence-based clinical guidelines or algorithms are embedded in the medical management system
- 31 to guide case managers through assessment and ongoing management of a Member;
- 32
- 33 2. A documentation process that includes automated notation of the staff members' identification,
- 34 date, and time of entry, and records each action or interaction with the Member, Primary Care
- 35 Practitioner (PCP), or Provider; and
- 36
- 37 3. Automated prompts and reminders for next steps and follow-up care and contact scheduled with the
- 38 Member.
- 39
- 40 J. CalOptima Health and a Health Network shall provide Practitioners and Members, or caregivers as
- 41 applicable, with written information about the Case Management program, to include the following:
- 42
- 43 1. Instructions to the Practitioner on how to use the Case Management services, and how to refer a
- 44 Member;
- 45
- 46 2. Instructions to the Member or caregiver on how to self-refer to the Case Management program; and
- 47
- 48 3. Information regarding how CalOptima Health or the Health Network works with a Member in the
- 49 Case Management program.
- 50
- 51 K. On an annual basis, CalOptima Health shall evaluate Member satisfaction with CalOptima Health's or
- 52 the Health Network's Case Management program. CalOptima Health shall use the following to evaluate
- 53 Member satisfaction:

1. Obtaining Member feedback;
2. Analyzing Member complaints and inquiries; and
3. Reporting the results of the evaluation to the Member Experience Committee.

L. CalOptima Health shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Health Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

- A. CalOptima Health Contract with the Department of Health Care Services for Medi-Cal
- B. CalOptima Health Contract for Health Care Services
- C. Coordination and Provision of Public Health Care Services Contract
- D. CalOptima Health Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program
- E. CalOptima Health Policy GG.1324: Care Management and Coordination Process
- F. CalOptima Health Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Health Services
- G. CalOptima Health Policy GG.1330: Case Management – California Children's Services Program/Whole-Child Model
- H. CalOptima Health Policy GG.1352: Private Duty Nursing Care Management
- I. CalOptima Health Policy GG.1619: Delegation Oversight
- J. CalOptima Health Policy GG.1667: CalAIM Population Health Management Program
- K. Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21
- L. Case Management Society of America (CMSA): Standards of Practice for Case Management
- M. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Service Whole Child Model Program (Supersedes APL 23-034)
- N. Department of Health Care Services (DHCS) All Plan Letter (APL) 26-009: Private Duty Nursing Supersedes APL 20-012)
- O. National Committee for Quality Assurance (NCQA) 2026 PHM 5: Complex Case Management
- P. Title 22, California Code of Regulations (C.C.R.), §51185
- Q. ZeOmega Evidence-Based Clinical Protocol; Revised 03/18/25

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency	Response
09/09/2015	Department of Health Care Services (DHCS)	NR-90
01/20/2016	Department of Health Care Services (DHCS)	NR-90
06/21/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/07/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/14/2023	Department of Health Care Services (DHCS)	Approved as Submitted
09/09/2026	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/04/2009	Regular Meeting of the CalOptima Board of Directors
06/03/2021	Regular Meeting of the CalOptima Board of Directors [Ratification]

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2010	GG.1301	Case Management Process	Medi-Cal
Revised	08/01/2011	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2013	GG.1301	Case Management Process	Medi-Cal
Revised	01/01/2014	GG.1301	Complex Case Management Process	Medi-Cal
Revised	04/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	11/01/2015	GG.1301	Complex Case Management Process	Medi-Cal
Revised	10/01/2016	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	07/01/2017	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	05/01/2021	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	06/01/2022	GG.1301	Comprehensive Case Management Process	Medi-Cal
Revised	03/01/2023	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	07/01/2023	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	04/01/2025	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	07/01/2025	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised	09/01/2025	GG.1301	Comprehensive Care Management Process	Medi-Cal
Revised		GG.1301	Comprehensive Care Management Process	Medi-Cal

1 IX. GLOSSARY

2

Term	Definition
Authorized Representative	<u>Covered California</u>: 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 DHCS State Fair Hearings, 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. <u>Medi-Cal</u>: Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Basic Population Health Management (BPHM)	An approach to care that ensures that needed programs and services are made available to each member, regardless of their risk tier, at the right time and in the right setting. BPHM includes federal requirements for care coordination (as defined in 42 C.F.R. § 438.208).
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Care Coordination	Care coordination involves deliberately organizing member care activities and sharing information among all of those involved with patient care. CalOptima Health's coordination of care delivery and services for Members, either within or across delivery systems including services the Member receives by CalOptima Health, any other managed care health plan; Fee-For-Service (FFS); Out-of-Network Providers; carve-out programs, such as pharmacy, Substance Use Disorder (SUD), mental health, and dental services; and community and social support Providers. Care Coordination services may be included in Basic Case Management, Complex Case Management, Enhanced Care Management (ECM), Person Centered Planning and Transitional Care Services.
Care Management	A systematic approach to coordination of care for a Member with special needs and/or complex medical conditions that includes the elements of assessment, care planning, intervention monitoring, and documentation.
Children and Youth with Special Health Care Needs (CYSHCN)	Children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally. The identification, assessment, treatment, and coordination of care for CYSHCN shall comply with the requirements of 42, CFR, Sections 438.208(b)(3) and (b)(4), and 42 CFR Sections 438.208(c)(2), (c)(3), and (c)(4).

Term	Definition
Complex Care/Case Management	An approach to care management that meets differing needs of high-and rising-risk members, including both longer-term chronic care coordination and interventions for episodic, temporary needs. Medi-Cal Managed care plans (MCPs) must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements
Complex Case Management Eligible Member	Members who are at high-risk; defined as having medically complex conditions that may include the following but is not limited to: 1. Spinal Injuries; 2. Transplants; 3. Cancer; 4. Serious trauma; 5. AIDS; 6. Multiple chronic illnesses; or 7. Chronic illnesses that result in high utilization. Or Member with a medical condition and a complex social situation that affects the medical management of the Member's care and requires extensive use of resources.
Continuity of Care	<u>Covered California</u> : Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship. <u>Medi-Cal</u> : Services provided to a Member rendered by an out-of-network provider with whom the Member has a pre-existing provider relationship.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
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 Risk Assessment (HRA)	An assessment required for Seniors and Persons with Disabilities. Effective January 1, 2023, HRA assessment requirements for Seniors and Persons with Disabilities are simplified, while specific member protections are kept in place.
Individual Care Plan (ICP)	A plan of care developed after an assessment of the Member's social and health care needs that reflects the Member's resources, understanding of his or her disease process, and lifestyle choices.
Medically Fragile Persons (Targeted Case Management Services program)	Those persons who require ongoing or intermittent medical supervision without which their health status would deteriorate to an acute episode.
Medically Necessary or Medical Necessity	<u>Covered California</u> : Services provided to a Member rendered by an out-of-Network Provider with whom the Member has a pre-existing Provider relationship. <u>Medi-Cal</u> : Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically

Term	Definition
	Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medical Management Program	For purposes of this policy: Disease management programs, utilization management programs, health information lines or similar programs that can identify needs for Complex Case Management and are managed by organization or vendor staff.
Member	An individual enrolled in a CalOptima Health program.
Primary Care Practitioner/Physician (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a primary care physician or non-physician medical practitioner. <u>Medi-Cal</u>: A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a Specialty Care Provider or clinic.
Private Duty Nursing (PDN)	An Early Periodic Screening, Detection, and Treatment (EPSDT) Supplemental Service that includes Medically Necessary services provided to Members who require continuous in-home nursing care.
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services. <u>Medi-Cal</u>: 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.

Term	Definition
Service Area	<u>Covered California</u>: The county or counties in which CalOptima Health is approved to operate under the terms of its QHP Contract with the Exchange. The service area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by the Exchange for CalOptima Health to operate under the terms of the QHP Contract. <u>Medi-Cal</u>: The county or counties that CalOptima Health is approved to operate in under the terms of the DHCS contract. Currently, this covers Orange County, California.
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. Also known as Health Related Social Needs.
Targeted Case Management	Services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

1



Policy: CC.2100
Title: **CalOptima Health Covered Health Assessment and Case Management**
Department: Case Management
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2027

Revised Date: N/A

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

I. PURPOSE

This policy defines the process for identification of and outreach to high-risk active CalOptima Health Covered California (CCA) Members for Health Assessment (HA) and case management.

II. POLICY

- A. CalOptima Health shall outreach to Members for a HA who are high risk and active CCA Members.
- B. Members shall be referred to the appropriate level of Case Management based on the results of the HA.
- C. The delegated Health Networks for CCA must follow all NCQA CCM criteria as outlined in CalOptima Health Policy GG.1301: Comprehensive Care Management Process.
- D. The delegated Health Network shall use the HA to outreach to the Member for enrollment into case management.
- E. The delegated Health Network is responsible for providing Case Management for Covered California Members. Case Management includes a complete assessment of a Member's condition, determination of available benefits and resources, and development and implementation of an Individualized Care Plan (ICP) with goals and interventions, monitoring, and follow-up.
- F. Health Network shall ensure the provision of Discharge Planning and Care Coordination to high-risk Members who are hospitalized and institutionalized.
- G. Health Network shall ensure enrolled Members are offered an Interdisciplinary Care Team (ICT) meeting in accordance with the Member's functional status, assessed needs, and ICP.
- H. Health Network shall ensure ongoing assessment of Member needs as they transition in and out of case management levels.
- I. Health Network shall ensure coordination of care and provision of all Medically Necessary Covered Services delivered within or outside of the contracted Provider network.

III. PROCEDURE

A. HA Risk Stratification

1. CalOptima Health will attempt to complete an HA for CCA Members who are identified as high risk. This is defined by the following:
 - a. Internal risk stratification tool to identify Members who are high risk;
 - b. Pregnant;
 - c. Undergoing active cancer treatment; or
 - d. Undergoing medication assisted treatment for substance use disorders.

B. HA tool shall identify the following elements:

1. Access to care needs;
2. Medications;
3. Chronic conditions; and
4. Health care utilization (ER visits, Hospital admissions).

C. HA Outreach

1. CalOptima Health shall make three (3) attempts to reach the Member by phone.
2. Call attempts will be completed within sixty (60) calendar days of identification.
3. Members who do not respond or are unreachable will receive an Unable to Contact (UTC) letter.
4. Members who refuse to complete a HA will be documented in CalOptima Health medical management system and outreach efforts will cease for the HA.

D. HA Analysis and Evaluation

1. CalOptima Health shall enter all information in the HA into a CalOptima Health medical management system.
2. Based on the results of the HA information, a Care Management Level (CML) of Basic, Care Coordination or Complex Case Management will be determined.
 - a. Basic case management, provided by the Primary Care Provider (PCP), in collaboration with CalOptima Health or a Health Network; or
 - b. Care Coordination and Complex case management, provided by a Health Network in collaboration with the PCP.

3. The HA with assigned CML shall be uploaded periodically throughout the day in an automated process to CalOptima Health's secure File Transfer Protocol (FTP) site. HA files shall include responses for each HA question and each Member's overall CML level.
4. The delegated HN shall be responsible for sharing all HA results with the Member's PCP.
5. The delegated HN shall be responsible for following up with Members flagged at Care Coordination or Complex Case Management for case management services.

E. Case Management Referrals

1. Based on HA responses, CCA Members shall be referred to either:
 - a. Basic case management, provided by the Primary Care Provider (PCP) in collaboration with the delegated Health Network; or
 - b. Care coordination and Complex Case Management, provided by the delegated Health Network in collaboration with the PCP.
2. Health Network shall ensure that higher risk Members receive Complex Case Management, in accordance with CalOptima Health Policy GG.1301: Comprehensive Care Management.
3. A Member may be referred for Case Management by various sources including but not limited to self-referral, the Member's Authorized Representative, the Member's family or caregiver, community agency, Health Network, Provider, Practitioner, discharge planner, or Utilization Management program.
4. Health Network may receive referrals by electronic transmission, telephone, or written correspondence.

F. Provision of Case Management Services to Case Management enrolled Members

1. Members enrolled in Complex Case Management:
 - a. Health Network shall provide Complex Case Management services in accordance with CalOptima Health Policy GG.1301: Comprehensive Care Management.
2. Members enrolled in Care Coordination:
 - a. Health Network shall obtain the Member's consent prior to initiating Case Management.
 - b. Health Network shall ensure to complete a comprehensive assessment of an eligible Member's health care status, condition-specific issues, support systems and resources, to determine the need for any medical, educational, social, or other services and benefits.
 - c. Health Network shall conduct a reassessment of a case management enrolled Member under the following circumstances:
 - i. With changes to Member's health status;
 - ii. With identification of barriers; and

- 1 iii. At least annually.
- 2
- 3 d. Health Network shall develop an ICP, in conjunction with the Provider, Member and/or
- 4 their caregiver.
- 5
- 6 i. The ICP shall include prioritized goals, personalized to meet a Member's specific
- 7 needs.
- 8
- 9 3. Health Network shall offer an ICT to all Members enrolled with case management.
- 10
- 11 a. The ICT will work closely with a Member to stabilize medical conditions, increase
- 12 compliance with ICPs, maintain functional status and meet individual Member ICP goals.
- 13
- 14 b. The ICT core participants include but are not limited to:
- 15
- 16 i. Member/Member representative;
- 17
- 18 ii. Primary Care Provider (PCP);
- 19
- 20 iii. Health Network Medical Director; and
- 21
- 22 iv. Case Manager.
- 23
- 24 4. Health Network shall ensure communication and sharing of the Member's HA and ICP to the
- 25 Member, Member's PCP, and all participants of the ICT.
- 26
- 27 a. Health Network shall provide Member Information, and Interpreter services in accordance
- 28 with CalOptima Health Policy DD.2002: Cultural and Linguistic Services.
- 29
- 30 5. Health Network shall ensure Members enrolled in CM will:
- 31
- 32 a. Assess and update ICP goals and interventions in accordance with the Member's needs;
- 33
- 34 b. Identify barriers to meeting goals or complying with the ICP;
- 35
- 36 c. Facilitate Member referrals to resources to address barriers;
- 37
- 38 d. Close the loop on referrals;
- 39
- 40 e. Provide post-hospitalization coordination support for Members experiencing a transition of
- 41 care.
- 42
- 43 6. While Member is enrolled with case management, no less than annually or as needed based on
- 44 Member need, Health Network shall update a Member's ICP based on the Member's level of
- 45 complexity and clinical needs.
- 46
- 47 G. Provision of case management for high-risk Members experiencing a hospital admission
- 48
- 49 1. All Members receiving case management will receive ongoing support for post-hospitalization
- 50 coordination needs.
- 51

2. Health Network shall receive Key Event report for high-risk Members who have an inpatient admission.
3. Health Network must outreach to the Member within seven (7) calendar days of discharge.
4. Health Network must assess Member for the following needs and assist as needed:
 - a. PCP follow up
 - b. Medication changes
 - c. Durable Medical Equipment needs
 - d. Home Health needs
 - e. Community Referrals needs
5. If a Member needs continued assistance, Health Network shall refer to their case management for ongoing support and assistance.

H. Case Management Case Closure

1. Health Network shall terminate a Case Management case when the Member:
 - a. Declines case management;
 - b. Becomes ineligible with Health Network; or
 - c. Has met his or her goals.
- I. CalOptima Health shall monitor a Health Network's Case Management program, in accordance with this Policy and CalOptima Health Policy GG.1619: Delegation Oversight.
- J. CalOptima Health shall conduct quarterly oversight audits to ensure compliance with CalOptima Health Policies and Procedures. Audit feedback shall be provided quarterly upon completion to the Health Networks.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Contract with Covered California
- B. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
- C. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
- D. CalOptima Health Policy GG.1619: Delegation Oversight

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

1 **VII. BOARD ACTION(S)**

2

Date	Meeting
10/01/2026	Regular Meeting of the CalOptima Health Board of Directors

3
4 **VIII. REVISION HISTORY**

5

Action	Date	Policy	Policy Title	Program(s)
Effective		CC.2100	CalOptima Health Covered Health Assessment and Case Management	Covered California

6

For 20261001 BOD Review Only

IX. GLOSSARY

Term	Definition
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 DHCS State Fair Hearings, 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.
Health Network	A medical group that is a Participating Health Care Provider that is contracted with CalOptima Health to provide Covered Benefits to Members.
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).
Member	An individual enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	The National Committee for Quality Assurance, a nonprofit accreditation agency.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a primary care physician or non-physician medical practitioner.
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.



CalOptima Health

UNAUDITED FINANCIAL STATEMENTS

August 31, 2026

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**CalOptima Health - Consolidated
Financial Highlights
For the Two Months Ending August 31, 2026**

August 2026									July 2026 - August 2026			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance				
794,688	774,025	20,663	2.7%	Member Months	1,596,171	1,555,977	40,194	2.6%				
380,616,142	371,626,945	8,989,196	2.4%	Revenues	763,724,732	746,927,764	16,796,968	2.2%				
369,143,666	360,644,083	(8,499,583)	(2.4%)	Medical Expenses ¹	729,447,269	724,049,474	(5,397,795)	(0.7%)				
20,890,957	24,825,286	3,934,329	15.8%	Administrative Expenses	43,699,008	50,744,159	7,045,151	13.9%				
(9,418,481)	(13,842,424)	4,423,942	32.0%	Operating Margin	(9,421,545)	(27,865,870)	18,444,325	66.2%				
				Non-Operating Income (Loss)								
11,399,143	8,333,330	3,065,813	36.8%	Net Investment Income/Expense	19,947,614	16,666,660	3,280,954	19.7%				
(555,000)	-	(555,000)	(100.0%)	Grant Expense	(1,294,907)	-	(1,294,907)	(100.0%)				
574,761	-	574,761	100.0%	Community Reinvestment	794,112	-	794,112	100.0%				
668,550	(172,007)	840,557	488.7%	Other Income/Expense	(307,039)	(344,014)	36,975	10.7%				
12,087,453	8,161,323	3,926,130	48.1%	Total Non-Operating Income (Loss)	19,139,780	16,322,646	2,817,134	17.3%				
2,668,972	(5,681,101)	8,350,073	147.0%	Change in Net Assets	9,718,235	(11,543,224)	21,261,459	184.2%				
97.0%	97.0%	0.0%		Medical Loss Ratio	95.5%	96.9%	(1.4%)					
5.5%	6.7%	1.2%		Administrative Loss Ratio	5.7%	6.8%	1.1%					
(2.5%)	(3.7%)	1.3%		Operating Margin Ratio	(1.2%)	(3.7%)	2.5%					
100.0%	100.0%			Total Operating	100.0%	100.0%						

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

**CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Two Months Ending August 31, 2026**

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,313	1,411	98
OneCare	167	183	16
PACE	111	121	10
CCA	23	25	2
MSSP	21	24	3
Total	1,636	1,764	128

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	2,631	2,823	192
OneCare	336	366	30
PACE	224	241	17
CCA	39	49	10
MSSP	42	48	6
Total	3,272	3,527	255

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	590	534	(56)
OneCare	115	107	(8)
PACE	5	5	0
CCA	0	0	0
MSSP	27	24	(3)
Consolidated	486	439	(47)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	592	537	(55)
OneCare	113	106	(7)
PACE	5	5	0
CCA	0	0	0
MSSP	27	24	(3)
Consolidated	488	441	(47)

Open FTE			
	Total	Medical	Admin
Medi-Cal	74	33	41
OneCare	8	4	4
PACE	9	8	1
CCA	16	3	13
MSSP	2	2	0
Total	109	50	59

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending August 31, 2026

MEMBER MONTHS	794,688		774,025		20,663	
	Actual		Budget		Variance	
REVENUE	\$	PMPM	\$	PMPM	\$	PMPM
Medi-Cal	\$337,363,419	\$435.33	\$327,314,134	\$434.13	\$10,049,284	\$1.20
OneCare	37,495,696	1,958.41	38,770,715	1,989.14	(1,275,019)	(30.73)
PACE	5,522,908	9,505.87	5,283,669	9,173.04	239,239	332.83
MSSP	234,119	418.82	258,427	446.33	(24,308)	(27.51)
Total Operating Revenue	380,616,142	478.95	371,626,945	480.12	8,989,196	(1.17)
MEDICAL EXPENSES						
Medi-Cal	328,324,706	423.67	318,564,083	422.52	(9,760,623)	(1.15)
OneCare	36,022,859	1,881.48	36,864,511	1,891.34	841,652	9.86
PACE	4,610,674	7,935.76	4,806,195	8,344.09	195,520	408.33
MSSP	185,427	331.71	240,929	416.11	55,502	84.40
Covered CA			168,365		168,365	
Total Medical Expenses	369,143,666	464.51	360,644,083	465.93	(8,499,583)	1.42
GROSS MARGIN	11,472,475	14.44	10,982,862	14.19	489,613	0.25
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,041,920	15.56	13,505,477	17.45	1,463,557	1.89
Professional Fees	1,800,168	2.33	2,016,465	2.61	216,297	0.28
Purchased Services	1,990,452	2.57	2,466,647	3.19	476,194	0.62
Printing & Postage	237,845	0.31	513,323	0.66	275,478	0.35
Depreciation & Amortization	1,167,825	1.51	1,117,682	1.44	(50,143)	(0.07)
Other Expenses	3,075,898	3.97	4,632,852	5.99	1,556,953	2.02
Indirect Cost Allocation, Occupancy	576,848	0.75	572,841	0.74	(4,007)	(0.01)
Total Administrative Expenses	20,890,957	26.29	24,825,286	32.07	3,934,329	5.78
NET INCOME (LOSS) FROM OPERATIONS	(9,418,481)	(11.85)	(13,842,424)	(17.88)	4,423,942	6.03
INVESTMENT INCOME						
Interest Income	13,699,692	17.24	8,582,330	11.09	5,117,362	6.15
Realized Gain/(Loss) on Investments	(603,874)	(0.76)	-	-	(603,874)	(0.76)
Unrealized Gain/(Loss) on Investments	(1,482,819)	(1.87)	-	-	(1,482,819)	(1.87)
Investment Fees	(213,856)	(0.27)	(249,000)	(0.32)	35,144	0.05
Total Investment Income	11,399,143	14.34	8,333,330	10.77	3,065,813	3.57
NET BUILDING INCOME/EXPENSE	(136,030)	(0.17)	(172,007)	(0.22)	35,977	0.05
NET MCO TAX	802,619	1.01	-	-	802,619	1.01
GRANT EXPENSE	(555,000)	(0.70)	-	-	(555,000)	(0.70)
COMMUNITY REINVESTMENT	574,761	0.72	-	-	574,761	0.72
OTHER INCOME/EXPENSE	1,960	-	-	-	1,960	-
CHANGE IN NET ASSETS	2,668,972	3.36	(5,681,101)	(7.34)	8,350,073	10.70
MEDICAL LOSS RATIO	97.0%		97.0%		(0.1%)	
ADMINISTRATIVE LOSS RATIO	5.5%		6.7%		1.2%	

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026

MEMBER MONTHS	1,596,171		1,555,977		40,194	
	Actual		Budget		Variance	
REVENUE	\$	PMPM	\$	PMPM	\$	PMPM
Medi-Cal	\$677,506,685	\$435.16	\$658,398,582	\$434.31	\$19,108,103	\$0.85
OneCare	74,971,357	1,967.29	77,470,647	1,993.07	(2,499,290)	(25.78)
PACE	10,778,298	9,339.95	10,542,574	9,183.43	235,724	156.52
MSSP	468,392	416.35	515,961	446.33	(47,569)	(29.98)
Total Operating Revenue	763,724,732	478.47	746,927,764	480.04	16,796,968	(1.57)
MEDICAL EXPENSES						
Medi-Cal	647,901,087	416.15	639,870,950	422.09	(8,030,137)	5.94
OneCare	72,475,609	1,901.80	73,686,260	1,895.71	1,210,651	(6.09)
PACE	8,681,055	7,522.58	9,657,445	8,412.41	976,391	889.83
MSSP	389,519	346.24	498,088	430.87	108,569	84.63
Covered CA			336,730		336,730	
Total Medical Expenses	729,447,269	457.00	724,049,474	465.33	(5,397,795)	8.33
GROSS MARGIN	34,277,463	21.47	22,878,289	14.71	11,399,174	6.76
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	26,193,121	16.83	28,104,541	18.06	1,911,420	1.23
Professional Fees	3,072,005	1.97	4,032,930	2.59	960,925	0.62
Purchased Services	4,357,050	2.80	4,933,380	3.17	576,331	0.37
Printing & Postage	415,650	0.27	1,026,646	0.66	610,996	0.39
Depreciation & Amortization	2,571,966	1.65	2,235,364	1.44	(336,602)	(0.21)
Other Expenses	6,010,868	3.86	9,265,616	5.95	3,254,748	2.09
Indirect Cost Allocation, Occupancy	1,078,348	0.69	1,145,682	0.74	67,334	0.05
Total Administrative Expenses	43,699,008	27.38	50,744,159	32.61	7,045,151	5.23
NET INCOME (LOSS) FROM OPERATIONS	(9,421,545)	(5.90)	(27,865,870)	(17.91)	18,444,325	12.01
INVESTMENT INCOME						
Interest Income	27,509,239	17.23	17,164,660	11.03	10,344,579	6.20
Realized Gain/(Loss) on Investments	(1,626,224)	(1.02)	-	-	(1,626,224)	(1.02)
Unrealized Gain/(Loss) on Investments	(5,529,688)	(3.46)	-	-	(5,529,688)	(3.46)
Investment Fees	(405,713)	(0.25)	(498,000)	(0.32)	92,287	0.07
Total Investment Income	19,947,614	12.50	16,666,660	10.71	3,280,954	1.79
NET BUILDING INCOME/EXPENSE	(310,714)	(0.19)	(344,014)	(0.22)	29,016	0.03
GRANT EXPENSE	(1,294,907)	(0.81)	-	-	(1,294,907)	(0.81)
COMMUNITY REINVESTMENT	794,112	0.50	-	-	794,112	0.50
OTHER INCOME/EXPENSE	3,675	-	-	-	3,675	-
CHANGE IN NET ASSETS	9,718,235	6.09	(11,543,224)	(7.42)	21,261,459	13.51
MEDICAL LOSS RATIO	95.5%		96.9%		(1.4%)	
ADMINISTRATIVE LOSS RATIO	5.7%		6.8%		1.1%	

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending August 31, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	774,961	19,146	581	559		794,688
REVENUES						
Capitation Revenue	\$ 337,363,419	\$ 37,495,696	\$ 5,522,908	\$ 234,119	\$ -	\$ 380,616,142
Total Operating Revenue	337,363,419	37,495,696	5,522,908	234,119	-	380,616,142
MEDICAL EXPENSES						
Provider Capitation	109,743,821	14,053,760				123,797,581
Facility and Professional Claims	152,147,058	9,584,719	2,556,265			164,288,042
MLTSS	51,066,348		98,504	20,530		51,185,382
Prescription Drugs		10,351,140	543,301			10,894,442
Case Mgmt & Other Medical	15,367,480	2,033,239	1,412,604	164,897		18,978,220
Total Medical Expenses	328,324,706	36,022,859	4,610,674	185,427	-	369,143,666
<i>Medical Loss Ratio</i>	<i>97.3%</i>	<i>96.1%</i>	<i>83.5%</i>	<i>79.2%</i>	<i>0.0%</i>	<i>97.0%</i>
GROSS MARGIN	9,038,712	1,472,837	912,234	48,693	-	11,472,475
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	10,346,010	1,054,011	194,985	109,145	337,768	12,041,920
Non-Salary Operating Expenses	3,220,475	557,891	71,137	1,533	177,430	4,028,465
Depreciation & Amortization	1,166,698		1,128			1,167,825
Other Operating Expenses	3,038,396	7,336	22,757	8,709	(1,299)	3,075,898
Indirect Cost Allocation, Occupancy	(628,836)	1,180,470	17,384	7,830		576,848
Total Administrative Expenses	17,142,743	2,799,708	307,390	127,217	513,898	20,890,957
<i>Administrative Loss Ratio</i>	<i>5.1%</i>	<i>7.5%</i>	<i>5.6%</i>	<i>54.3%</i>	<i>0.0%</i>	<i>5.5%</i>
Operating Income/(Loss)	(8,104,031)	(1,326,872)	604,843	(78,524)	(513,898)	(9,418,481)
Investments and Other Non-Operating	1,404,502					12,087,453
CHANGE IN NET ASSETS	\$ (6,699,529)	\$ (1,326,872)	\$ 604,843	\$ (78,524)	\$ (513,898)	\$ 2,668,972
BUDGETED CHANGE IN NET ASSETS	(11,268,942)	(1,317,428)	135,069	(112,088)	(1,279,034)	(5,681,101)
Variance to Budget - Fav/(Unfav)	\$ 4,569,412	\$ (9,443)	\$ 469,775	\$ 33,564	\$ 765,136	\$ 8,350,073

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ending August 31, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	1,556,908	38,109	1,154	1,125		1,596,171
REVENUES						
Capitation Revenue	\$ 677,506,685	\$ 74,971,357	\$ 10,778,298	\$ 468,392	\$ -	\$ 763,724,732
Total Operating Revenue	677,506,685	74,971,357	10,778,298	468,392	-	763,724,732
MEDICAL EXPENSES						
Provider Capitation	220,531,253	27,861,604				248,392,857
Facility and Professional Claims	291,710,871	19,153,174	4,484,213			315,348,258
MLTSS	101,318,472		163,356	39,866		101,521,694
Prescription Drugs		20,866,719	1,105,213			21,971,933
Case Mgmt & Other Medical	34,340,490	4,594,112	2,928,273	349,653		42,212,528
Total Medical Expenses	647,901,087	72,475,609	8,681,055	389,519	-	729,447,269
<i>Medical Loss Ratio</i>	<i>95.6%</i>	<i>96.7%</i>	<i>80.5%</i>	<i>83.2%</i>	<i>0.0%</i>	<i>95.5%</i>
GROSS MARGIN	29,605,599	2,495,748	2,097,244	78,873	-	34,277,463
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	22,736,493	2,198,113	420,136	225,626	612,752	26,193,121
Non-Salary Operating Expenses	6,287,439	996,011	101,923	3,062	456,270	7,844,705
Depreciation & Amortization	2,569,711		2,255			2,571,966
Other Operating Expenses	5,919,388	45,270	30,676	15,492	42	6,010,868
Indirect Cost Allocation, Occupancy	(1,326,132)	2,354,140	34,680	15,660		1,078,348
Total Administrative Expenses	36,186,898	5,593,534	589,671	259,840	1,069,065	43,699,008
<i>Administrative Loss Ratio</i>	<i>5.3%</i>	<i>7.5%</i>	<i>5.5%</i>	<i>55.5%</i>	<i>0.0%</i>	<i>5.7%</i>
Operating Income/(Loss)	(6,581,299)	(3,097,786)	1,507,572	(180,967)	(1,069,065)	(9,421,545)
Investments and Other Non-Operating	797,787					19,139,780
CHANGE IN NET ASSETS	\$ (5,783,513)	\$ (3,097,786)	\$ 1,507,572	\$ (180,967)	\$ (1,069,065)	\$ 9,718,235
BUDGETED CHANGE IN NET ASSETS	(22,468,953)	(2,747,453)	184,520	(249,648)	(2,584,335)	(11,543,224)
Variance to Budget - Fav/(Unfav)	\$ 16,685,441	\$ (350,333)	\$ 1,323,052	\$ 68,681	\$ 1,515,271	\$ 21,261,459

CalOptima Health

Highlights – Consolidated, for the Two Months Ending August 31, 2026

MONTH TO DATE RESULTS:

- Change in Net Assets is \$2.7 million, favorable to budget \$8.4 million
- Operating deficit is \$9.4 million, with a surplus in non-operating income of \$12.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is \$9.7 million, favorable to budget \$21.3 million
- Operating deficit is \$9.4 million, with a surplus in non-operating income of \$19.1 million

Change in Net Assets by Line of Business (LOB) (\$ millions):

August 2026				July 2026 - August 2026		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
(8.1)	(11.3)	3.2	Operating Income (Loss)	(6.6)	(22.5)	15.9
(1.3)	(1.3)	0.0	Medi-Cal	(3.1)	(2.7)	(0.4)
0.6	0.1	0.5	OneCare	1.5	0.2	1.3
(0.1)	(0.1)	0.0	PACE	(0.2)	(0.2)	0.1
(0.5)	(1.3)	0.8	MSSP	(1.1)	(2.6)	1.5
(9.4)	(13.8)	4.4	Covered CA	(9.4)	(27.9)	18.4
			Total Operating Income (Loss)			
			Non-Operating Income (Loss)			
11.4	8.3	3.1	Net Investment Income/Expense	19.9	16.7	3.3
0.7	(0.2)	0.9	Other Income/Expense	0.0	(0.8)	(0.3)
12.1	8.2	3.9	Total Non-Operating Income/(Loss)	19.1	16.3	2.8
2.7	(5.7)	8.4	TOTAL	9.7	(11.5)	21.3

**CalOptima Health - Consolidated
Enrollment Summary
For the Two Months Ending August 31, 2026**

August 2026				Enrollment (by Aid Category)	July 2026 - August 2026			
Actual	Budget	\$ Variance	%Variance		Actual	Budget	\$ Variance	%Variance
104,521	101,791	2,730	2.7%	Adult	210,541	204,821	5,720	2.8%
230,888	227,727	3,161	1.4%	Child	463,776	457,405	6,371	1.4%
280,525	269,663	10,862	4.0%	Expansion	563,778	543,326	20,452	3.8%
3,018	3,176	(158)	(5.0%)	LTC	6,022	6,352	(330)	(5.2%)
147,702	143,052	4,650	3.3%	SPD	295,871	286,926	8,945	3.1%
8,307	8,548	(241)	(2.8%)	Whole Child Model	16,920	17,128	(208)	(1.2%)
774,961	753,957	21,004	2.8%	Medi-Cal Total	1,556,908	1,515,959	40,949	2.7%
19,146	19,491	(345)	(1.8%)	OneCare	38,109	38,870	(761)	(2.0%)
581	576	5	0.9%	PACE	1,154	1,148	6	0.5%
559	579	(20)	(3.5%)	MSSP	1,125	1,156	(31)	(2.7%)
794,688	774,025	20,663	2.7%	CalOptima Health Total	1,596,171	1,555,977	40,194	2.6%

				Enrollment (by Network)				
Actual	Budget	\$ Variance	%Variance		Actual	Budget	\$ Variance	%Variance
295,852	285,105	10,747	3.8%	HMO	595,369	574,452	20,917	3.6%
149,364	143,772	5,592	3.9%	PHC	299,596	289,186	10,410	3.6%
72,313	64,633	7,680	11.9%	Shared Risk Group	144,936	129,788	15,148	11.7%
257,432	260,447	(3,015)	(1.2%)	Fee for Service	517,007	522,533	(5,526)	(1.1%)
774,961	753,957	21,004	2.8%	Medi-Cal Total	1,556,908	1,515,959	40,949	2.7%
19,146	19,491	(345)	(1.8%)	OneCare	38,109	38,870	(761)	(2.0%)
581	576	5	0.9%	PACE	1,154	1,148	6	0.5%
559	579	(20)	(3.5%)	MSSP	1,125	1,156	(31)	(2.7%)
794,688	774,025	20,663	2.7%	CalOptima Health Total	1,596,171	1,555,977	40,194	2.6%

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											112,356	109,340	3,016
Child	66,323	65,482											131,805	130,934	871
Expansion	156,202	154,485											310,687	293,921	16,766
LTC		1											1		1
SPD	19,058	18,886											37,944	37,586	358
Whole Child Model	1,336	1,240											2,576	2,671	(95)
Total	299,517	295,852											595,369	574,452	20,917
PHCs															
Adult	2,971	2,916											5,887	5,554	333
Child	118,528	117,898											236,426	230,964	5,462
Default Code		0											0		0
Expansion	18,332	18,184											36,516	32,354	4,162
LTC	1	0											1		1
SPD	4,462	4,547											9,009	8,452	557
Whole Child Model	5,938	5,819											11,757	11,863	(106)
Total	150,232	149,364											299,596	289,186	10,410
Shared Risk Groups															
Adult	12,566	12,566											25,132	24,728	404
Child	20,692	20,574											41,266	40,099	1,167
Expansion	35,090	34,844											69,934	56,305	13,629
LTC	4	0											4		4
SPD	3,955	4,037											7,992	7,874	118
Whole Child Model	316	292											608	783	(175)
Total	72,623	72,313											144,936	129,788	15,148
Fee for Service (Dual)															
Adult	737	748											1,485	1,044	441
Expansion	2,524	2,565											5,089	6,166	(1,077)
LTC	2,679	2,679											5,358	5,604	(246)
SPD	107,375	107,026											214,401	206,267	8,134
Whole Child Model	10	10											20	21	(1)
Total	113,325	113,028											226,353	219,102	7,251
Fee for Service (Non-Dual - Total)															
Adult	33,148	32,533											65,681	64,156	1,525
Child	27,345	26,934											54,279	55,407	(1,128)
Expansion	71,105	70,447											141,552	154,580	(13,028)
LTC	320	338											658	748	(90)
SPD	13,319	13,206											26,525	26,747	(222)
Whole Child Model	1,013	946											1,959	1,791	168
Total	146,250	144,404											290,654	303,431	(12,777)
Grand Totals															
Total MediCal MM	781,947	774,961											1,556,908	1,515,959	40,949
OneCare	18,963	19,146											38,109	38,870	(761)
PACE	573	581											1,154	1,148	6
MSSP	566	559											1,125	1,156	(31)
Grand Total	801,483	794,688											1,596,171	1,555,977	40,194

Note:* Total membership does not include MSSP

ENROLLMENT– AUGUST MONTH:

Overall, August enrollment was 794,688

- Favorable to budget 20,663 or 2.7%
- Decreased 6,795 or 0.8% from Prior Month (PM) (July 2026)
- Decreased 97,124 or 10.9% from Prior Year (PY) (August 2025)

Medi-Cal enrollment was 774,961

- Favorable to budget 21,004 or 2.8%
- Medi-Cal Expansion (MCE) enrollment favorable to budget 10,862
- Seniors and Persons with Disabilities (SPD) enrollment favorable to budget 4,650
- Child (CHD) enrollment favorable to budget 3,161
- Adult (FAM) enrollment favorable to budget 2,730
- Whole Child Model (WCM) enrollment unfavorable to budget 241
- Long-Term Care (LTC) enrollment unfavorable to budget 158
- Decreased 6,986 or 0.9% from PM

OneCare enrollment was 19,146

- Unfavorable to budget 345 or 1.8%
- Increased 183 or 1.0% from PM

PACE enrollment was 581

- Favorable to budget 5 or 0.9%
- Increased 8 or 1.4% from PM

MSSP enrollment was 559

- Unfavorable to budget 20 or 3.5%
- Decreased 7 or 1.2% from PM

**CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026**

August 2026			
Actual	Budget	\$ Variance	% Variance
774,961	753,957	21,004	2.8%
337,363,419	327,314,134	10,049,284	3.1%
337,363,419	327,314,134	10,049,284	3.1%
109,743,821	106,998,880	(2,744,941)	(2.6%)
67,108,076	70,397,944	3,289,868	4.7%
85,038,982	71,121,027	(13,917,954)	(19.6%)
51,066,348	48,492,841	(2,573,506)	(5.3%)
3,996,381	7,989,461	3,993,079	50.0%
7,827,916	10,495,342	2,667,426	25.4%
3,543,183	3,068,588	(474,595)	(15.5%)
328,324,706	318,564,083	(9,760,623)	(3.1%)
9,038,712	8,750,051	288,661	3.3%
10,346,010	11,363,408	1,017,398	9.0%
1,558,591	1,653,427	94,836	5.7%
1,530,349	1,675,988	145,639	8.7%
131,535	324,409	192,874	59.5%
1,166,698	1,116,060	(50,638)	(4.5%)
3,038,396	4,543,369	1,504,972	33.1%
(628,836)	(657,667)	(28,831)	(4.4%)
17,142,743	20,018,993	2,876,250	14.4%
(8,104,031)	(11,268,942)	3,164,911	28.1%
574,761	-	574,761	0.0%
802,619	-	802,619	0.0%
25,162	-	25,162	0.0%
-	-	-	0.0%
1,960	-	1,960	0.0%
1,404,502	-	1,404,502	100.0%
(6,699,529)	(11,268,942)	4,569,412	40.5%

97.3% 97.3% (0.0%)
5.1% 6.1% 1.0%

	July 2026 - August 2026			
	Actual	Budget	\$ Variance	% Variance
Member Months	1,556,908	1,515,959	40,949	2.7%
Revenues				
Capitation Revenue	677,506,685	658,398,582	19,108,103	2.9%
Total Operating Revenue	677,506,685	658,398,582	19,108,103	2.9%
Medical Expenses				
Provider Capitation	220,531,253	215,606,684	(4,924,569)	(2.3%)
Facilities Claims	130,381,833	140,963,269	10,581,435	7.5%
Professional Claims	161,329,038	142,361,000	(18,968,038)	(13.3%)
MLTSS	101,318,472	97,159,734	(4,158,738)	(4.3%)
Incentive Payments	10,858,371	16,027,673	5,169,302	32.3%
Medical Management	16,463,823	21,585,251	5,121,427	23.7%
Other Medical Expenses	7,018,295	6,167,339	(850,956)	(13.8%)
Total Medical Expenses	647,901,087	639,870,950	(8,030,137)	(1.3%)
Gross Margin	29,605,599	18,527,632	11,077,967	59.8%
Administrative Expenses				
Salaries, Wages & Employee Benefits	22,736,493	23,685,415	948,922	4.0%
Professional Fees	2,625,980	3,306,854	680,874	20.6%
Purchased Services	3,434,209	3,352,062	(82,147)	(2.5%)
Printing & Postage	227,249	648,818	421,569	65.0%
Depreciation & Amortization	2,569,711	2,232,120	(337,591)	(15.1%)
Other Operating Expenses	5,919,388	9,086,650	3,167,262	34.9%
Indirect Cost Allocation, Occupancy	(1,326,132)	(1,315,334)	10,798	0.8%
Total Administrative Expenses	36,186,898	40,996,585	4,809,687	11.7%
Income (Loss) From Operations	(6,581,299)	(22,468,953)	15,887,654	70.7%
Non-Operating Income (Loss)				
Community Reinvestment	794,112	-	794,112	100.0%
Total Operating Tax	-	-	-	0.0%
Grant Expense	-	-	-	0.0%
Net QAF & IGT Income/ Expense	-	-	-	0.0%
Other Income/Expense	3,675	-	3,675	100.0%
Total Non-Operating Income/(Loss)	797,787	-	797,787	100.0%
Change in Net Assets	(5,783,513)	(22,468,953)	16,685,441	74.3%

Medical Loss Ratio 95.6% 97.2% (1.6%)
Admin Loss Ratio 5.3% 6.2% 0.9%

MEDI-CAL INCOME STATEMENT– AUGUST MONTH:

REVENUES are \$337.4 million, favorable to budget \$10.0 million:

- Favorable volume-related variance of \$9.1 million
- Favorable price-related variance of \$0.9 million

MEDICAL EXPENSES are \$328.3 million, unfavorable to budget \$9.8 million:

- Unfavorable volume-related variance of \$8.9 million
- Unfavorable price-related variance of \$0.9 million
 - Professional Claims expense unfavorable variance of \$11.9 million due primarily to increase utilization in enhanced care management and mental health
 - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of \$1.2 million
 - Other Medical Expenses unfavorable variance of \$0.4 million
 - Offset by:
 - Facilities Claims expense favorable variance of \$5.3 million due primarily to decrease in outpatient claims
 - Incentive Payments expense favorable variance of \$4.2 million
 - Medical Management expense favorable variance of \$3.0 million
 - Provider Capitation expense favorable variance of \$0.2 million

ADMINISTRATIVE EXPENSES are \$17.1 million, favorable to budget \$2.9 million:

- Non-Salary expense favorable to budget \$1.9 million
- Salaries, Wages & Employee Benefits expense favorable variance of \$1.0 million

NON-OPERATING INCOME/(LOSS) is \$1.4 million, favorable to budget \$1.4 million

CHANGE IN NET ASSETS is (\$6.7) million, favorable to budget \$4.6 million

**CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026**

August 2026					July 2026 - August 2026			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
19,146	19,491	(345)	(1.8%)	Member Months	38,109	38,870	(761)	(2.0%)
				Revenues				
27,147,541	27,296,888	(149,346)	(0.5%)	Medicare Part C	53,614,655	54,615,542	(1,000,887)	(1.8%)
10,348,155	11,473,827	(1,125,673)	(9.8%)	Medicare Part D	21,356,702	22,855,105	(1,498,403)	(6.6%)
							-	
37,495,696	38,770,715	(1,275,019)	(3.3%)	Total Operating Revenue	74,971,357	77,470,647	(2,499,290)	(3.2%)
				Medical Expenses				
14,053,760	14,866,437	812,676	5.5%	Provider Capitation	27,861,604	29,785,506	1,923,902	6.5%
6,676,463	6,065,765	(610,698)	(10.1%)	Facilities Claims	13,399,808	12,063,015	(1,336,793)	(11.1%)
2,908,257	2,573,524	(334,732)	(13.0%)	Professional Claims	5,753,366	5,115,005	(638,361)	(12.5%)
10,351,140	11,080,101	728,961	6.6%	Prescription Drugs	20,866,719	22,076,923	1,210,203	5.5%
520,706	459,173	(61,533)	(13.4%)	Incentive Payments	1,047,904	924,550	(123,354)	(13.3%)
1,014,230	1,292,080	277,850	21.5%	Medical Management	2,075,764	2,669,440	593,676	22.2%
498,303	527,431	29,128	5.5%	Other Medical Expenses	1,470,444	1,051,822	(418,622)	(39.8%)
36,022,859	36,864,511	841,652	2.3%	Total Medical Expenses	72,475,609	73,686,260	1,210,651	1.6%
				Gross Margin	2,495,748	3,784,387	(1,288,639)	(34.1%)
1,472,837	1,906,204	(433,367)	(22.7%)	Administrative Expenses				
				Salaries, Wages & Employee Benefits	2,198,113	2,511,566	313,453	12.5%
1,054,011	1,213,495	159,484	13.1%	Professional Fees	127,273	257,600	130,327	50.6%
135,027	128,800	(6,227)	(4.8%)	Purchased Services	683,151	946,494	263,343	27.8%
319,526	473,247	153,721	32.5%	Printing & Postage	185,586	274,212	88,626	32.3%
103,339	137,106	33,767	24.6%	Other Operating Expenses	45,270	132,802	87,532	65.9%
7,336	66,401	59,065	89.0%	Indirect Cost Allocation, Occupancy	2,354,140	2,409,166	55,026	2.3%
1,180,470	1,204,583	24,113	2.0%	Total Administrative Expenses	5,593,534	6,531,840	938,306	14.4%
2,799,708	3,223,632	423,924	13.2%	Change in Net Assets	(3,097,786)	(2,747,453)	(350,333)	(12.8%)
(1,326,872)	(1,317,428)	(9,443)	(0.7%)					
				Medical Loss Ratio	96.7%	95.1%	1.6%	
96.1%	95.1%	1.0%		Admin Loss Ratio	7.5%	8.4%	1.0%	
7.5%	8.3%	0.8%						

ONECARE INCOME STATEMENT – AUGUST MONTH:

REVENUES are \$37.5 million, unfavorable to budget \$1.3 million:

- Unfavorable volume-related variance of \$0.7 million
- Unfavorable price-related variance of \$0.6 million

MEDICAL EXPENSES are \$36.0 million, favorable to budget \$0.8 million:

- Favorable volume-related variance of \$0.7 million
- Favorable price-related variance of \$0.2 million
 - Provider Capitation expense favorable variance of \$0.5 million
 - Prescription Drugs expense favorable variance of \$0.5 million
 - Medical Management expense favorable variance of \$0.3 million
 - Offset by:
 - Facilities Claims expense unfavorable variance of \$0.7 million
 - Professional Claims expense unfavorable variance of \$0.4 million

ADMINISTRATIVE EXPENSES are \$2.8 million, favorable to budget \$0.4 million

- Non-Salary expense favorable to budget \$0.3 million
- Salaries, Wages & Employee Benefits expense favorable to budget \$0.2 million

CHANGE IN NET ASSETS is (\$1.3) million, unfavorable to budget \$9,443

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026

August 2026				July 2026 - August 2026				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
581	576	5	0.9%	Member Months	1,154	1,148	6	0.5%
				Revenues				
4,022,194	3,964,335	57,859	1.5%	Medi-Cal Capitation Revenue	7,998,058	7,901,140	96,918	1.2%
1,138,028	925,501	212,526	23.0%	Medicare Part C Revenue	2,058,965	1,854,280	204,686	11.0%
362,687	393,833	(31,147)	(7.9%)	Medicare Part D Revenue	721,275	787,154	(65,879)	(8.4%)
5,522,908	5,283,669	239,239	4.5%	Total Operating Revenue	10,778,298	10,542,574	235,724	2.2%
				Medical Expenses				
1,412,604	1,717,820	305,216	17.8%	Medical Management	2,928,273	3,530,070	601,798	17.0%
1,173,648	1,099,975	(73,673)	(6.7%)	Facilities Claims	2,033,458	2,181,078	147,620	6.8%
1,054,307	914,819	(139,489)	(15.2%)	Professional Claims	1,762,916	1,816,087	53,171	2.9%
543,301	641,296	97,994	15.3%	Prescription Drugs	1,105,213	1,273,776	168,563	13.2%
98,504	108,571	10,068	9.3%	MLTSS	163,356	213,004	49,648	23.3%
328,310	320,339	(7,971)	(2.5%)	Patient Transportation	687,838	636,681	(51,158)	(8.0%)
-	3,375	3,375	100.0%	Other Medical Expenses	-	6,750	6,750	100.0%
4,610,674	4,806,195	195,520	4.1%	Total Medical Expenses	8,681,055	9,657,445	976,391	10.1%
912,234	477,475	434,759	91.1%	Gross Margin	2,097,244	885,128	1,212,115	136.9%
				Administrative Expenses				
194,985	201,470	6,485	3.2%	Salaries, Wages & Employee Benefits	420,136	418,736	(1,400)	(0.3%)
3,111	10,433	7,322	70.2%	Professional Fees	3,123	20,866	17,743	85.0%
65,055	76,551	11,496	15.0%	Purchased Services	95,985	153,102	57,117	37.3%
2,971	21,801	18,830	86.4%	Printing & Postage	2,814	43,602	40,788	93.5%
1,128	1,622	494	30.5%	Depreciation & Amortization	2,255	3,244	989	30.5%
22,757	12,437	(10,320)	(83.0%)	Other Operating Expenses	30,676	24,874	(5,802)	(23.3%)
17,384	18,092	708	3.9%	Indirect Cost Allocation, Occupancy	34,680	36,184	1,504	4.2%
307,390	342,406	35,016	10.2%	Total Administrative Expenses	589,671	700,608	110,937	15.8%
604,843	135,069	469,775	347.8%	Change in Net Assets	1,507,572	184,520	1,323,052	717.0%
83.5%	91.0%	(7.5%)		Medical Loss Ratio	80.5%	91.6%	(11.1%)	
5.6%	6.5%	0.9%		Admin Loss Ratio	5.5%	6.6%	1.2%	

**CalOptima Health
MSSP
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026**

August 2026					July 2026 - August 2026			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
559	579	(20)	(3.5%)	Member Months	1,125	1,156	(31)	(2.7%)
				Revenues				
234,119	258,427	(24,308)	(9.4%)	Medi-Cal Capitation Revenue	468,392	515,961	(47,569)	(9.2%)
234,119	258,427	(24,308)	(9.4%)	Total Operating Revenue	468,392	515,961	(47,569)	(9.2%)
				Medical Expenses				
164,897	206,810	41,913	20.3%	Medical Management	349,653	429,850	80,197	18.7%
20,530	34,119	13,589	39.8%	Waiver Services	39,866	68,238	28,372	41.6%
185,427	240,929	55,502	23.0%	Total Program Expenses	389,519	498,088	108,569	21.8%
				Gross Margin				
48,693	17,498	31,195	178.3%		78,873	17,873	61,000	341.3%
				Administrative Expenses				
109,145	113,879	4,734	4.2%	Salaries, Wages & Employee Benefits	225,626	236,107	10,481	4.4%
1,530	1,583	53	3.4%	Professional Fees	3,060	3,166	106	3.4%
3	-	(3)	(100.0%)	Purchased Services	3	-	(3)	(100.0%)
8,709	6,291	(2,418)	(38.4%)	Other Operating Expenses	15,492	12,582	(2,910)	(23.1%)
7,830	7,833	3	0.0%	Indirect Cost Allocation, Occupancy	15,660	15,666	6	0.0%
127,217	129,586	2,369	1.8%	Total Administrative Expenses	259,840	267,521	7,681	2.9%
(78,524)	(112,088)	33,564	29.9%	Change in Net Assets	(180,967)	(249,648)	68,681	27.5%
				Medical Loss Ratio	83.2%	96.5%	(13.4%)	
79.2%	93.2%	(14.0%)		Admin Loss Ratio	55.5%	51.8%	(3.6%)	
54.3%	50.1%	(4.2%)						

**CalOptima Health
Covered California
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026**

August 2026					July 2026 - August 2026			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
-	-	-	0.0%	Member Months	-	-	-	0.0%
-	-	-	0.0%	Revenues	-	-	-	0.0%
-	-	-	0.0%	Capitation Revenue	-	-	-	0.0%
-	-	-	0.0%	Total Operating Revenue	-	-	-	0.0%
-	168,365	168,365	100.0%	Medical Expenses	-	336,730	336,730	100.0%
-	168,365	168,365	100.0%	Medical Management	-	336,730	336,730	100.0%
-	(168,365)	168,365	(100.0%)	Total Medical Expenses	-	(336,730)	336,730	(100.0%)
337,768	613,225	275,457	44.9%	Gross Margin	612,752	1,252,717	639,965	51.1%
101,910	222,222	120,312	54.1%	Administrative Expenses	312,569	444,444	131,875	29.7%
75,520	240,861	165,341	68.6%	Salaries, Wages & Employee Benefits	143,702	481,722	338,020	70.2%
-	30,007	30,007	100.0%	Professional Fees	-	60,014	60,014	100.0%
-	-	-	0.0%	Purchased Services	-	-	-	0.0%
(1,299)	4,354	5,653	129.8%	Printing & Postage	42	8,708	8,666	99.5%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
513,898	1,110,669	596,771	53.7%	Other Operating Expenses	-	-	-	0.0%
(513,898)	(1,279,034)	765,136	59.8%	Indirect Cost Allocation, Occupancy	1,069,065	2,247,605	1,178,540	52.4%
(513,898)	(1,279,034)	765,136	59.8%	Total Administrative Expenses	(1,069,065)	(2,584,335)	1,515,271	58.6%
0.0%	0.0%	0.0%		Income (Loss) From Operations	(1,069,065)	(2,584,335)	1,515,271	58.6%
0.0%	0.0%	0.0%		Change in Net Assets	(1,069,065)	(2,584,335)	1,515,271	58.6%
				Medical Loss Ratio	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 Two Months Ending August 31, 2026

August 2026			
Actual	Budget	\$ Variance	% Variance
-	-	-	0.0%
-	-	-	0.0%
92,654	29,814	(62,840)	(210.8%)
194,267	208,333	14,066	6.8%
21,938	23,583	1,645	7.0%
223,692	305,563	81,871	26.8%
103,233	61,231	(42,002)	(68.6%)
(635,784)	(628,525)	7,259	1.2%
-	-	-	0.0%
-	-	-	0.0%

Revenues
Building Income
Total Operating Revenue

Administrative Expenses
Purchased Services
Depreciation & Amortization
Insurance Expense
Repair & Maintenance
Other Operating Expenses
Indirect Cost Allocation, Occupancy
Total Administrative Expenses

Change in Net Assets

July 2026 - August 2026			
		\$	%
Actual	Budget	Variance	Variance
-	-	-	0.0%
-	-	-	0.0%
186,684	59,628	(127,056)	(213.1%)
388,533	416,666	28,133	6.8%
43,875	47,166	3,291	7.0%
405,392	611,126	205,734	33.7%
192,883	122,462	(70,421)	(57.5%)
(1,217,367)	(1,257,050)	(39,683)	(3.2%)
-	-	-	0.0%
-	-	-	0.0%

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026

August 2026			
Actual	Budget	\$ Variance	% Variance
143,883	130,249	13,634	10.5%
143,883	130,249	13,634	10.5%
67,830	13,350	(54,480)	(408.1%)
85,131	116,667	31,536	27.0%
8,220	8,417	197	2.3%
52,209	174,314	122,105	70.0%
37,496	32,319	(5,177)	(16.0%)
(25,903)	(127,856)	(101,953)	(79.7%)
224,983	217,211	(7,772)	(3.6%)
(81,100)	(86,962)	5,862	6.7%

Revenues
Building Income
Total Operating Revenue
Administrative Expenses
Purchased Services
Depreciation & Amortization
Insurance Expense
Repair & Maintenance
Other Operating Expenses
Indirect Cost Allocation, Occupancy
Total Administrative Expenses
Change in Net Assets

July 2026 - August 2026			
Actual	Budget	\$ Variance	% Variance
291,656	260,498	31,158	12.0%
291,656	260,498	31,158	12.0%
137,300	26,700	(110,600)	(414.2%)
175,418	233,334	57,916	24.8%
16,027	16,834	807	4.8%
134,585	348,628	214,043	61.4%
82,860	64,638	(18,222)	(28.2%)
(57,177)	(255,712)	(198,535)	(77.6%)
489,014	434,422	(54,592)	(12.6%)
(197,358)	(173,924)	(23,434)	(13.5%)

CalOptima Health
Building 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2026

August 2026			
Actual	Budget	\$ Variance	% Variance
-	-	-	0.0%
-	-	-	0.0%
37,422	3,333	(34,089)	(1022.8%)
9,397	16,667	7,270	43.6%
4,984	4,724	(260)	(5.5%)
1,177	47,868	46,691	97.5%
1,950	12,454	10,504	84.3%
54,930	85,046	30,116	35.4%
(54,930)	(85,046)	30,116	35.4%

Revenues
Building Income
Total Operating Revenue
Administrative Expenses
Purchased Services
Depreciation & Amortization
Insurance Expense
Repair & Maintenance
Other Operating Expenses
Total Administrative Expenses
Change in Net Assets

July 2026 - August 2026			
Actual	Budget	\$ Variance	% Variance
-	-	-	0.0%
-	-	-	0.0%
73,682	6,666	(67,016)	(1005.3%)
18,795	33,334	14,539	43.6%
9,967	9,448	(519)	(5.5%)
7,235	95,736	88,501	92.4%
3,677	24,908	21,231	85.2%
113,356	170,092	56,736	33.4%
(113,356)	(170,092)	56,736	33.4%

OTHER PROGRAM INCOME STATEMENTS – AUGUST MONTH:

PACE

- **CHANGE IN NET ASSETS** is \$0.6 million, favorable to budget \$0.5 million

MSSP

- **CHANGE IN NET ASSETS** is (\$78,524), favorable to budget \$33,564

Covered CA

- **CHANGE IN NET ASSETS** is (\$0.5) million, favorable to budget \$0.8 million

NON-OPERATING INCOME STATEMENTS – AUGUST MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is (\$81,100), favorable to budget \$5,862

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is (\$54,930), favorable to budget \$30,116

INVESTMENT INCOME

- Net Investment Income of \$11.4 million due to \$13.5 million in net interest income, offset by \$2.1 million in realized and unrealized loss on investments

CalOptima Health
Balance Sheet
August 31, 2026

		<u>August-26</u>	<u>July-26</u>	<u>\$ Change</u>	<u>% Change</u>
ASSETS					
Current Assets					
	Operating Cash	386,002,219	307,617,458	78,384,761	25.5%
	Short-term Investments	1,725,622,247	1,766,257,739	(40,635,492)	(2.3%)
	Receivables - Other	20,493,255	19,467,547	1,025,708	5.3%
	Prepaid Expenses	24,603,925	20,717,916	3,886,009	18.8%
	Capitation Receivables	605,914,116	604,121,761	1,792,355	0.3%
	Total Current Assets	2,762,635,762	2,718,182,421	44,453,341	1.6%
	Total Capital Assets, Net	125,804,811	113,878,987	11,925,824	10.5%
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	1,643,348,180	1,639,075,098	4,273,082	0.3%
	Statutory Designated Reserves	141,775,715	141,467,152	308,563	0.2%
	Total Designated Assets	1,785,123,895	1,780,542,251	4,581,645	0.3%
TOTAL ASSETS		4,677,933,550	4,616,972,740	60,960,810	1.3%
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 68 - PERS - Difference in Earnings	-	-	-	0.0%
	GASB 75 - OPEB - Contributions	721,000	721,000	-	0.0%
	GASB 75 - OPEB - Changes in Assumptions	276,000	276,000	-	0.0%
	GASB 53 - INVT - Changes in Fair Value	-	-	-	0.0%
	Advance Discretionary Payment	-	-	-	0.0%
TOTAL ASSETS & DEFERRED OUTFLOWS		4,708,856,563	4,647,895,753	60,960,810	1.3%

CalOptima Health
Balance Sheet
August 31, 2026

		<u>August-26</u>	<u>July-26</u>	<u>\$ Change</u>	<u>% Change</u>
LIABILITIES					
Current Liabilities					
	Accounts Payable	176,979,538	103,412,813	73,566,725	71.1%
	Accrued Payroll Liabilities	26,601,685	26,840,572	(238,887)	(0.9%)
	Deferred Revenue	5,921,439	43,890,070	(37,968,631)	(86.5%)
	Due to State of California and CMS	759,547,493	756,102,881	3,444,613	0.5%
	Medical Claims Liabilities				
	Consolidated	368,513	500,546	(132,033)	(26.4%)
	Medi-Cal	324,464,744	317,107,620	7,357,124	2.3%
	MSSP	-	-	-	0.0%
	OneCare Connect	4,065,700	4,065,700	-	0.0%
	OneCare	19,261,548	17,806,387	1,455,161	8.2%
	PACE	3,783,730	3,612,443	171,288	4.7%
	Medical Claims Liabilities	351,944,235	343,092,696	8,851,539	2.6%
	Capitation and Withholds	132,011,238	127,705,858	4,305,380	3.4%
	Total Current Liabilities	1,453,005,628	1,401,044,889	51,960,739	3.7%
	GASB 96 Subscription Liabilities	32,130,090	25,241,157	6,888,933	27.3%
	Capital Lease Payable	188,230	192,481	(4,251)	(2.2%)
	Community Reinvestment, Capital Lease Payable	66,147,226	66,721,987	(574,761)	(0.9%)
	Post Employment Health Benefits Liability	15,812,489	15,791,312	21,177	0.1%
	Net Pension Liabilities	-	-	-	0.0%
TOTAL LIABILITIES		1,567,283,664	1,508,991,826	58,291,838	3.9%
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	135,040,486	134,233,293	807,193	0.6%
	Funds in excess of TNE	2,989,809,220	2,987,947,441	1,861,779	0.1%
	Net Assets	3,124,849,706	3,122,180,734	2,668,972	0.1%
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		4,708,856,563	4,647,895,753	60,960,810	1.3%

BALANCE SHEET – AUGUST MONTH:

ASSETS of \$4.7 billion increased \$61.0 million from July or 1.3%

- Operating Cash and Short-term Investments increased \$37.7 million due primarily to the Managed Care Organization (MCO) tax revenue receipt of \$61.7 million, offset by routine operating costs
- Total Capital Assets, Net increased \$11.9 million due to activity due to a GASB 96 subscription liability asset addition
- Board Designated Assets increased \$4.6 million due to interest income of \$6.1 million, offset by losses from higher interest rates
- Prepaid Expenses increased \$3.9 million due to payment timing for annual service and maintenance contracts

LIABILITIES of \$1.6 billion increased \$58.3 million from July or 3.9%

- Accounts Payable increased \$73.6 million due to the MCO tax accrual
- Medical Claims Liabilities increased \$8.9 million due to variability in claims experience
- GASB 96 Subscription Liabilities increased \$6.9 million due to the recording of a new subscription based asset
- Capitation and Withholds increased \$4.3 million
- Deferred Revenue decreased \$38.0 million due to the recognition of last month's Centers for Medicare & Medicaid Services (CMS) capitation prepayment for August

NET ASSETS of \$3.1 billion, increased \$2.7 million from July or 1.3%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of August 31, 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	820,802,586				
MetLife Tier One	822,545,594				
Board Designated Reserves	1,643,348,180	1,080,221,833	1,728,354,933	563,126,347	(85,006,753)
<i>Current Reserve Level (X months of average monthly revenue) ¹</i>	<i>3.80</i>	<i>2.50</i>	<i>4.00</i>		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	70,954,029				
MetLife Tier Two	70,821,686				
Statutory Designated Reserves	141,775,715	135,040,486	148,544,534	6,735,229	(6,768,819)
<i>Current Reserve Level (X min. TNE) ¹</i>	<i>1.05</i>	<i>1.00</i>	<i>1.10</i>		

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

CalOptima Health
Statement of Cash Flow
August 31, 2026

	<u>July 2026</u>	<u>July - August 2026</u>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,668,972	9,718,235
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,698,091	1,698,091
Changes in assets and liabilities:		
Prepaid expenses and other	(3,886,009)	(9,586,366)
Capitation receivable	(2,818,063)	3,644,949
Medical claims liability	8,851,539	(10,535,241)
Deferred revenue	(37,968,631)	-
Payable to health networks	4,305,380	6,738,164
Accounts payable	73,566,725	(48,687,236)
Accrued payroll	(217,710)	(6,517,002)
Other accrued liabilities	9,754,535	(36,161,925)
Net cash provided by/(used in) operating activities	<u>55,954,830</u>	<u>(89,688,331)</u>
 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	<u>-</u>	<u>-</u>
 CASH FLOWS FROM INVESTING ACTIVITIES:		
Change in Investments	40,635,492	134,455,594
Change in Property and Equipment	(13,623,915)	(17,232,508)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	-	-
Change in Homeless Health Reserve	(4,581,645)	(6,568,978)
Net cash provided by/(used in) investing activities	<u>22,429,932</u>	<u>110,654,108</u>
 NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	 78,384,761	 20,965,777
 CASH AND CASH EQUIVALENTS, beginning of period	 307,617,458	 365,036,442
 CASH AND CASH EQUIVALENTS, end of period	 <u>386,002,219</u>	 <u>386,002,219</u>

CalOptima Health
Spending Plan
For the Two Months Ending August 31, 2026

Item Description	Total Net Position @8/31/2026	Amount (millions) \$3,124.8	Approved Initiative	Expense to Date	% 100.0%
Resources Assigned					
Board Designated Reserve ¹		\$1,643.3			52.6%
Statutory Designated Reserve ¹		\$141.8			4.5%
Capital Assets, net of Depreciation		\$125.8			4.0%
Resources Allocated					
Homeless Health Initiative ²		14.1	63.3	49.2	0.5%
Housing and Homelessness Incentive ²		26.6	87.4	60.8	0.9%
Intergovernmental Transfers (IGT)		34.4	52.1	17.6	1.1%
Digital Transformation and Workplace Modernization ³		20.2	100.0	79.8	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	1.0	0.0%
Five-Year Hospital Quality Program Beginning MY 2023		101.8	153.5	51.7	3.3%
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		1.0	2.7	1.7	0.0%
CalOptima Health Provider Workforce Development Fund Grant		18.9	30.1	11.2	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)		70.2	526.2	456.0	2.2%
Medi-Cal Provider Rate Increases (07/2026 - 12/2028)		401.0	429.6	28.6	12.8%
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		29.1	29.5	0.4	0.9%
	Subtotal	781.5	1,607.1	825.6	25.0%
Resources Available for New Initiatives					
Unallocated/Unassigned ¹		\$432.4			13.8%

¹Total Designated Reserves and unallocated reserve amount can support approximately 178 days of CalOptima Health's current operations.

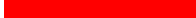
²See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

³On 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 August 31, 2026

	Item Name	August 2026				July 2026 -August 2026			
		Actual	Budget	Variance	%	Actual	Budget	Variance	%
Income Statement	Member Months	794,688	774,025	20,663	2.7%	1,596,171	1,555,977	40,194	2.6%
	Operating Revenue	380,616,142	371,626,945	8,989,196	2.4%	763,724,732	746,927,764	16,796,968	2.2%
	Medical Expenses	369,143,666	360,644,083	(8,499,583)	(2.4%)	729,447,269	724,049,474	(5,397,795)	(0.7%)
	General and Administrative Expense	20,890,957	24,825,286	3,934,329	15.8%	43,699,008	50,744,159	7,045,151	13.9%
	Non-Operating Income/(Loss)	12,087,453	8,161,323	3,926,130	48.1%	19,139,780	16,322,646	2,817,134	17.3%
	Summary of Income & Expenses	2,668,972	(5,681,101)	8,350,073	147.0%	9,718,235	(11,543,224)	21,261,459	184.2%
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated MLR	97.0%	97.0%	(0.1%)		95.5%	96.9%	(1.4%)	
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated ALR	5.5%	6.7%	1.2%		5.7%	6.8%	1.1%	

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@8/31/2026	3,480,860,904	3,511,712,027	(30,851,123)	(0.9%)
	Unallocated/Unassigned Reserve Balance	Current Month @August 2026	Fiscal Year Ending June 2026	Change	%
	Consolidated Days Cash On Hand*	432,393,533 178	357,469,971	74,923,562	21.0%

*Total Designated Reserves and unallocated reserve amount can support approximately 178 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy (\$100 million total reserve)
Funding Balance Tracking Summary
For the One Month Ending August 31, 2026

	August 2026				July - August 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	-	-	-	0.0%	223,150	-	(223,150)	0.0%	17,967,278	17,885,535	(81,743)	(0.5%)

Operating Expenses:												
Salaries, Wages & Benefits	-	-	-	0.0%	-	-	-	0.0%	17,826,058	17,826,058	-	0.0%
Professional Fees	-	283,333	283,333	100.0%	-	566,666	566,666	100.0%	10,404,073	10,970,739	566,666	5.2%
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	57,567	166,667	109,100	65.5%	57,567	333,334	275,767	82.7%	25,900,224	26,175,991	275,767	1.1%
Medical Management	-	-	-	0.0%	-	-	-	0.0%	5,502,156	5,502,156	-	0.0%
Total Operating Expenses	57,567	450,000	392,433	87.2%	57,567	900,000	842,433	93.6%	63,386,595	64,229,028	842,433	1.3%

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	17,967,278	10,748,673
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	57,567	5,342,433
Ending Funding Balance	2,555,020	18,646,125	16,091,106
Add: Prior year unspent Operating Budget	-		
Total available Funding	2,555,020		

¹ On the June 5, 2025, the Board approved a two-year extension through June 30, 2027. Staff will bring a request to close-out any remaining balances through future Board action

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 August 31, 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	49,245,955	12,250,050	-
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	49,245,955	54,150,050	-

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey) 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	5,034,955	4,853,959	IGT's
Vaccination Intervention and Member Incentive Strategy ²	54,649	54,649	-	IGT's
Street Medicine ³	14,279,077	9,806,971	4,472,106	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	49,245,955	54,150,050	
Transfer of funds to HHIP ⁴	(40,100,000)	-	(40,100,000)	
Program Total	63,296,005	49,245,955	14,050,050	

¹On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of \$40.1 million from HHI to HHIP.

²On 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.

³On 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).

⁴On 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.

⁵On 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 August 31, 2026

Summary by Funding Source:	Total Funds¹	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	65,931,189	65,931,189	34,733,595	31,197,594	-
Existing Reserves & HHI Transfer	87,384,530	87,384,530	60,820,559	26,563,971	-
Street Medicine Support Center - GG Building²	7,000,000	7,000,000	-	7,000,000	-
Total	160,315,719	160,315,719	95,554,154	64,761,565	-

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	9,968,205	6,246,325	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	166,822,185	\$95,554,154	\$71,268,031	
Transfer of funds to Street Medicine Support Center-GG Building	(7,000,000)	-	(\$7,000,000)	Existing Reserves
Program Total	159,822,185	95,554,154	64,268,031	

¹Total 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

²On 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 August 31, 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	Behavioral Health - Training & Seminars	Behavioral Health - Consulting	\$15,000	For Consulting

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.



Financial Summary

August 31, 2026

Board of Directors Meeting
October 1, 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:

August 2026

- Enrollment in August 2026 was favorable to budget by 20,663 or 2.7%, primarily driven by lower than projected disenrollment trend in Medi-Cal Family and Expansion categories
- Unfavorable Medical Expenses were primarily driven by large professional claims from prior periods that recorded in August, and higher utilization in behavioral health and CalAIM-related services

Financial Highlights

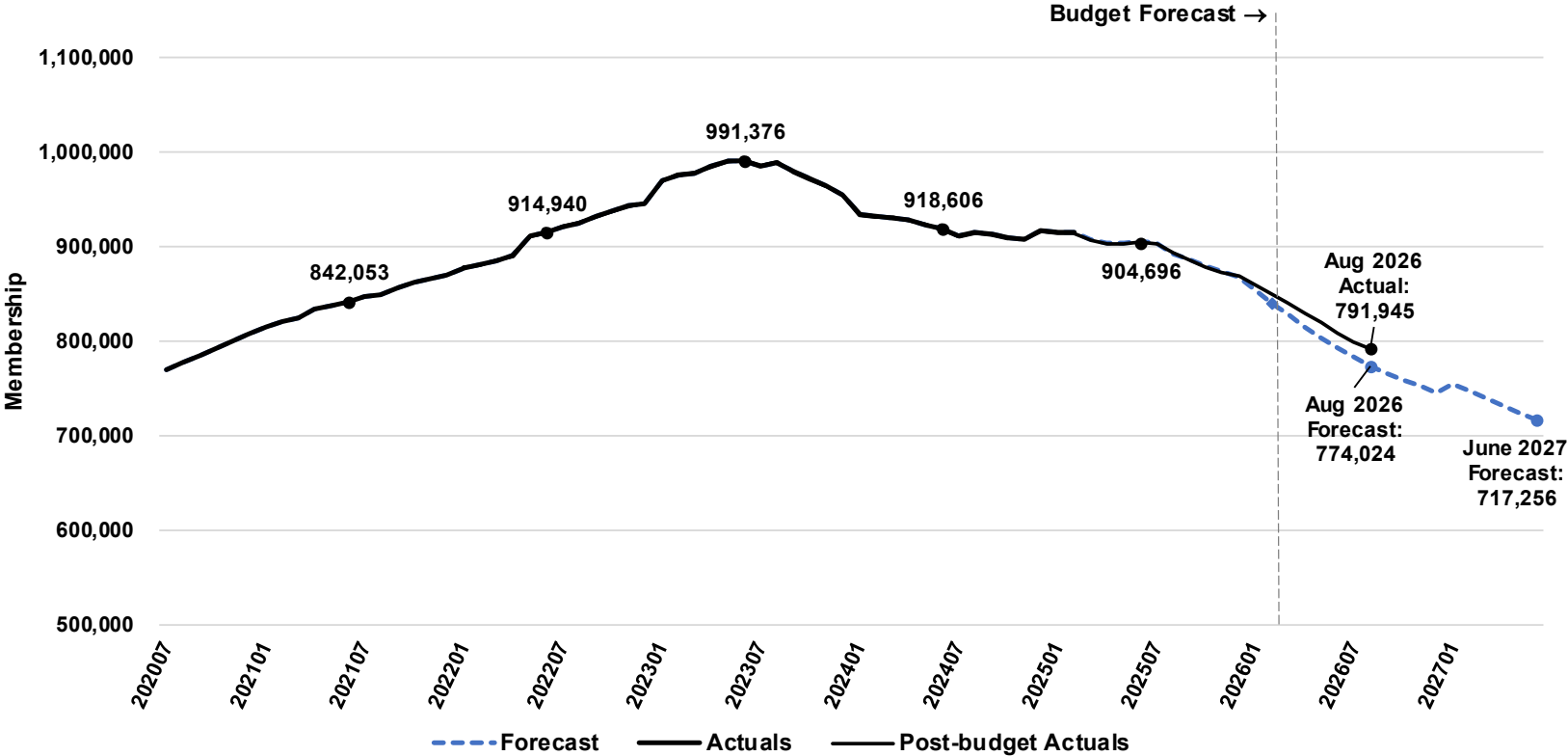
August 2026

August 2026					July 2026 - August 2026			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
794,688	774,025	20,663	2.7%	Member Months	1,596,171	1,555,977	40,194	2.6%
380,616,142	371,626,945	8,989,196	2.4%	Revenues	763,724,732	746,927,764	16,796,968	2.2%
369,143,666	360,644,083	(8,499,583)	(2.4%)	Medical Expenses ¹	729,447,269	724,049,474	(5,397,795)	(0.7%)
20,890,957	24,825,286	3,934,329	15.8%	Administrative Expenses	43,699,008	50,744,159	7,045,151	13.9%
(9,418,481)	(13,842,424)	4,423,942	32.0%	Operating Margin	(9,421,545)	(27,865,870)	18,444,325	66.2%
				Non-Operating Income (Loss)				
11,399,143	8,333,330	3,065,813	36.8%	Net Investment Income/Expense	19,947,614	16,666,660	3,280,954	19.7%
(555,000)	-	(555,000)	(100.0%)	Grant Expense	(1,294,907)	-	(1,294,907)	(100.0%)
574,761	-	574,761	100.0%	Community Reinvestment	794,112	-	794,112	100.0%
668,550	(172,007)	840,557	488.7%	Other Income/Expense	(307,039)	(344,014)	36,975	10.7%
12,087,453	8,161,323	3,926,130	48.1%	Total Non-Operating Income (Loss)	19,139,780	16,322,646	2,817,134	17.3%
2,668,972	(5,681,101)	8,350,073	147.0%	Change in Net Assets	9,718,235	(11,543,224)	21,261,459	184.2%
97.0%	97.0%	(0.1%)		Medical Loss Ratio	95.5%	96.9%	(1.4%)	
5.5%	6.7%	1.2%		Administrative Loss Ratio	5.7%	6.8%	1.1%	
(2.5%)	(3.7%)	1.3%		Operating Margin Ratio	(1.2%)	(3.7%)	2.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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

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 September 1, 2026



FY 2026-27: Management Summary

- Change in Net Assets Surplus or (Deficit)
 - Month To Date (MTD) August 2026: \$2.7 million, favorable to budget \$8.4 million or 147.0% driven by net investment income, and timing of administrative expense activities
 - Year To Date (YTD) July – August 2026: \$9.7 million, favorable to budget \$21.3 million or 184.2% driven by favorable enrollment, net investment income, and timing of administrative expense activities offset by unfavorable claim expenses

FY 2026-27: Management Summary (cont.)

○ Enrollment

- MTD: 794,688 members, favorable to budget 20,663 or 2.7% due to lower-than-expected disenrollment driven by federal and state policy changes and eligibility redetermination
- YTD: 1,596,171 members, favorable to budget 40,194 or 2.6% due to lower-than-expected disenrollment driven by federal and state policy changes and eligibility redetermination

FY 2026-27: Management Summary (cont.)

○ Revenue

- MTD: \$380.6 million, favorable to budget \$9.0 million or 2.4% due to:
 - \$9.1 million favorable volume variance to budget in Medi-Cal (MC) Line of Business (LOB) due to higher enrollment
 - Offset by \$0.7 million unfavorable volume variance to budget in OneCare (OC) LOB due to lower enrollment
- YTD: \$763.7 million, favorable to budget \$16.8 million or 2.2% due to:
 - \$17.8 million favorable volume variance to budget in MC LOB due to higher enrollment
 - Offset by \$1.5 million unfavorable volume variance to budget in OC LOB due to lower enrollment

FY 2026-27: Management Summary (cont.)

○ Medical Expenses

- MTD: \$369.1 million, unfavorable to budget \$8.5 million or 2.4% due to:
 - \$14.4 million in Professional Claims due to higher utilization
 - \$2.5 million in Managed Long-term Services and Supports (MLTSS)
 - \$1.9 million in Provider Capitation
 - Offset by favorable variances to budget:
 - \$3.9 million in Incentive Payments
 - \$3.5 million in Medical Management
 - \$2.6 million in Facilities Claims

FY 2026-27: Management Summary (cont.)

○ Medical Expenses (cont.)

- YTD: \$729.4 million, unfavorable to budget \$5.4 million or 0.7% due to:
 - \$8.0 million unfavorable to budget in MC LOB due to high utilization in Professional Claims, Provider Capitation, and MLTSS
 - Offset by:
 - \$1.2 million favorable to budget in OC LOB
 - \$1.0 million favorable to budget in PACE LOB

FY 2026-27: Management Summary (cont.)

○ Administrative Expenses

- MTD: \$20.9 million, favorable to budget \$3.9 million or 15.8% due to the timing of administrative expense activities
- YTD: \$43.7 million, favorable to budget \$7.0 million or 13.9% due to the timing of administrative expense activities

FY 2026-27: Management Summary (cont.)

○ Non-Operating Income (Loss)

- MTD: \$12.1 million, favorable to budget \$3.9 million or 48.1% due to:
 - \$3.1 million in Investment Income/Expense
 - \$0.8 million in Net Operating Tax
 - \$0.6 million in Community Reinvestment
 - Offset by \$0.6 million in Grant Expense
- YTD: \$19.1 million, favorable to budget \$2.8 million or 17.3% due to:
 - \$3.3 million in Investment Income/Expense
 - \$0.8 million in Community Reinvestment
 - Offset by \$1.3 million in Grant Expense

FY 2026-27: Key Financial Ratios

- Medical Loss Ratio (MLR)

	Actual	Budget	Variance (%)
MTD	97.0%	97.0%	(0.1%)
YTD	5.5%	6.7%	1.2%

- Administrative Loss Ratio (ALR)

	Actual	Budget	Variance (%)
MTD	95.5%	96.9%	(1.4%)
YTD	5.7%	6.8%	1.1%

FY 2026-27: Key Financials Ratios (cont.)

○ Balance Sheet Ratios

- Current ratio*: 1.9
- Board Designated Reserve level: 3.80
- Statutory Designated Reserve level: 1.05
- Net-position: \$3.1 billion, including required TNE of \$135.0 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

Enrollment Summary:

August 2026

August 2026					July 2026 - August 2026				
Actual	Budget	\$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	\$ Variance	% Variance	
104,521	101,791	2,730	2.7%	FAM	210,541	204,821	5,720	2.8%	
230,888	227,727	3,161	1.4%	CHD	463,776	457,405	6,371	1.4%	
280,525	269,663	10,862	4.0%	MCE	563,778	543,326	20,452	3.8%	
3,018	3,176	(158)	(5.0%)	LTC	6,022	6,352	(330)	(5.2%)	
147,702	143,052	4,650	3.3%	SPD	295,871	286,926	8,945	3.1%	
8,307	8,548	(241)	(2.8%)	WCM	16,920	17,128	(208)	(1.2%)	
774,961	753,957	21,004	2.8%	Medi-Cal Total	1,556,908	1,515,959	40,949	2.7%	
19,146	19,491	(345)	(1.8%)	OneCare	38,109	38,870	(761)	(2.0%)	
581	576	5	0.9%	PACE	1,154	1,148	6	0.5%	
559	579	(20)	(3.5%)	MSSP*	1,125	1,156	(31)	(2.7%)	
794,688	774,025	20,663	2.7%	CalOptima Health Total	1,596,171	1,555,977	40,194	2.6%	

*MSSP enrollment is included in Medi-Cal total

Consolidated Revenue & Expenses:

August 2026 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	774,961	19,146	581	559		794,688
REVENUES						
Capitation Revenue	\$ 337,363,419	\$ 37,495,696	\$ 5,522,908	\$ 234,119	\$ -	\$ 380,616,142
Total Operating Revenue	337,363,419	37,495,696	5,522,908	234,119	-	380,616,142
MEDICAL EXPENSES						
Provider Capitation	109,743,821	14,053,760				123,797,581
Facility and Professional Claims	152,147,058	9,584,719	2,556,265			164,288,042
MLTSS	51,066,348		98,504	20,530		51,185,382
Prescription Drugs		10,351,140	543,301			10,894,442
Case Mgmt & Other Medical	15,367,480	2,033,239	1,412,604	164,897		18,978,220
Total Medical Expenses	328,324,706	36,022,859	4,610,674	185,427	-	369,143,666
Medical Loss Ratio	97.3%	96.1%	83.5%	79.2%	0.0%	97.0%
GROSS MARGIN	9,038,712	1,472,837	912,234	48,693	-	11,472,475
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	10,346,010	1,054,011	194,985	109,145	337,768	12,041,920
Non-Salary Operating Expenses	3,220,475	557,891	71,137	1,533	177,430	4,028,465
Depreciation & Amortization	1,166,698		1,128			1,167,825
Other Operating Expenses	3,038,396	7,336	22,757	8,709	(1,299)	3,075,898
Indirect Cost Allocation, Occupancy	(628,836)	1,180,470	17,384	7,830		576,848
Total Administrative Expenses	17,142,743	2,799,708	307,390	127,217	513,898	20,890,957
Administrative Loss Ratio	5.1%	7.5%	5.6%	54.3%	0.0%	5.5%
Operating Income/(Loss)	(8,104,031)	(1,326,872)	604,843	(78,524)	(513,898)	(9,418,481)
Investments and Other Non-Operating	1,404,502					12,087,453
CHANGE IN NET ASSETS	\$ (6,699,529)	\$ (1,326,872)	\$ 604,843	\$ (78,524)	\$ (513,898)	\$ 2,668,972
BUDGETED CHANGE IN NET ASSETS	(11,268,942)	(1,317,428)	135,069	(112,088)	(1,279,034)	(5,681,101)
Variance to Budget - Fav/(Unfav)	\$ 4,569,412	\$ (9,443)	\$ 469,775	\$ 33,564	\$ 765,136	\$ 8,350,073

Consolidated Revenue & Expenses:

August 2026 YTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	1,556,908	38,109	1,154	1,125		1,596,171
REVENUES						
Capitation Revenue	\$ 677,506,685	\$ 74,971,357	\$ 10,778,298	\$ 468,392	\$ -	\$ 763,724,732
Total Operating Revenue	677,506,685	74,971,357	10,778,298	468,392	-	763,724,732
MEDICAL EXPENSES						
Provider Capitation	220,531,253	27,861,604				248,392,857
Facility and Professional Claims	291,710,871	19,153,174	4,484,213			315,348,258
MLTSS	101,318,472		163,356	39,866		101,521,694
Prescription Drugs		20,866,719	1,105,213			21,971,933
Case Mgmt & Other Medical	34,340,490	4,594,112	2,928,273	349,653		42,212,528
Total Medical Expenses	647,901,087	72,475,609	8,681,055	389,519	-	729,447,269
Medical Loss Ratio	95.6%	96.7%	80.5%	83.2%	0.0%	95.5%
GROSS MARGIN	29,605,599	2,495,748	2,097,244	78,873	-	34,277,463
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	22,736,493	2,198,113	420,136	225,626	612,752	26,193,121
Non-Salary Operating Expenses	6,287,439	996,011	101,923	3,062	456,270	7,844,705
Depreciation & Amortization	2,569,711		2,255			2,571,966
Other Operating Expenses	5,919,388	45,270	30,676	15,492	42	6,010,868
Indirect Cost Allocation, Occupancy	(1,326,132)	2,354,140	34,680	15,660		1,078,348
Total Administrative Expenses	36,186,898	5,593,534	589,671	259,840	1,069,065	43,699,008
Administrative Loss Ratio	5.3%	7.5%	5.5%	55.5%	0.0%	5.7%
Operating Income/(Loss)	(6,581,299)	(3,097,786)	1,507,572	(180,967)	(1,069,065)	(9,421,545)
Investments and Other Non-Operating	797,787					19,139,780
CHANGE IN NET ASSETS	\$ (5,783,513)	\$ (3,097,786)	\$ 1,507,572	\$ (180,967)	\$ (1,069,065)	\$ 9,718,235
BUDGETED CHANGE IN NET ASSETS	(22,468,953)	(2,747,453)	184,520	(249,648)	(2,584,335)	(11,543,224)
Variance to Budget - Fav/(Unfav)	\$ 16,685,441	\$ (350,333)	\$ 1,323,052	\$ 68,681	\$ 1,515,271	\$ 21,261,459

Balance Sheet: As of August 2026

ASSETS

Current Assets

Operating Cash	\$386,002,219
Short-term Investments	1,725,622,247
Capitation Receivable	605,914,116
Receivables - Other	20,493,255
Prepaid Expenses	24,603,925
Total Current Assets	2,762,635,762

Capital Assets

Capital Assets	222,873,809
Less: Accumulated Depreciation	(97,068,998)
Capital Assets, Net of Depreciation	125,804,811

Other Assets

Net Pension Assets	4,069,081
Restricted Deposit	300,000
Board Designated Reserves	1,643,348,180
Statutory Designated Reserves	141,775,715
Total Other Assets	1,789,492,976

TOTAL ASSETS	4,677,933,550
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Deferred Outflows	30,923,013
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TOTAL ASSETS & DEFERRED OUTFLOWS	\$4,708,856,563
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LIABILITIES & NET POSITION

Current Liabilities

Accounts Payable	\$176,979,538
Medical Claims Liability	351,944,235
Accrued Payroll Liabilities	26,601,685
Deferred Revenue	5,921,439
Due to State of California and CMS	759,547,493
Capitation and Withholds	132,011,238
Total Current Liabilities	1,453,005,628

Other Liabilities

GASB 96 Subscription Liabilities	32,130,090
Community Reinvestment	66,147,226
Capital Lease Payable	188,230
Post Employment Health Benefits Liability	15,812,489
Net Pension Liabilities	0
Total Other Liabilities	114,278,036

TOTAL LIABILITIES	1,567,283,664
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Deferred Inflows	16,723,193
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Net Position

Required TNE	135,040,486
Funds in Excess of TNE	2,989,809,220
TOTAL NET POSITION	3,124,849,706

TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	\$4,708,856,563
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Board Designated Reserve and TNE Analysis: As of August 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	820,802,586				
MetLife Tier One	822,545,594				
Board Designated Reserves	1,643,348,180	1,080,221,833	1,728,354,933	563,126,347	(85,006,753)
Current Reserve Level (X months of average monthly revenue) ¹		3.80	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	70,954,029				
MetLife Tier Two	70,821,686				
Statutory Designated Reserves	141,775,715	135,040,486	148,544,534	6,735,229	(6,768,819)
Current Reserve Level (X min. TNE) ¹		1.05	1.00	1.10	

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

Spending Plan: As of August 2026

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @8/31/2026	\$3,124.8			100.0%
Resources Assigned				
Board Designated Reserve ¹	\$1,643.3			52.6%
Statutory Designated Reserve ¹	\$141.8			4.5%
Capital Assets, net of Depreciation	\$125.8			4.0%
Resources Allocated				
Homeless Health Initiative (HHI) ²	14.1	63.3	49.2	0.5%
Housing and Homelessness Incentive Program (HHIP) ²	26.6	87.4	60.8	0.9%
Intergovernmental Transfers (IGT)	34.4	52.1	17.6	1.1%
Digital Transformation and Workplace Modernization ³	20.2	100.0	79.8	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	1.0	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	101.8	153.5	51.7	3.3%
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	1.0	2.7	1.7	0.0%
CalOptima Health Provider Workforce Development Fund Grant	18.9	30.1	11.2	0.6%
Garden Grove Bldg. Improvement	16.0	17.5	1.6	0.5%

Spending Plan: As of August 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)	70.2	526.2	456.0	2.2%
Medi-Cal Provider Rate Increases (07/2026 - 12/2028)	401.0	429.6	28.6	12.8%
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	29.1	29.5	0.4	0.9%
Subtotal	781.5	1,607.1	825.6	25.0%
Resources Available for New Initiatives				
Unallocated/Unassigned ¹	\$432.4			13.8%

¹Total Designated Reserves and unallocated reserve amount can support approximately 178 days of CalOptima Health's current operations.

²See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

³On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Homeless Health Initiative and Allocated Funds: As of August 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	49,245,955	12,250,050	-
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	49,245,955	54,150,050	-

Funds Allocation, Approved Initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey) 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	5,034,955	4,853,959	IGT's
Vaccination Intervention and Member Incentive Strategy ²	54,649	54,649	-	IGT's
Street Medicine ³	14,279,077	9,806,971	4,472,106	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	49,245,955	54,150,050	
Transfer of funds to HHIP ⁴	(40,100,000)	-	(40,100,000)	
Program Total	63,296,005	49,245,955	14,050,050	

¹On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of \$40.1 million from HHI to HHIP.

²On 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.

³On 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).

⁴On 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.

⁵On 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.



Housing and Homelessness Incentive Program: As of August 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	34,733,595	31,197,594	-
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	95,554,154	64,761,565	-

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	9,968,205	6,246,325	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	166,822,185	95,554,154	71,268,031	
Transfer of funds to Street Medicine Support Center-GG Building	(7,000,000)	-	(7,000,000)	Existing Reserves
Program Total	159,822,185	95,554,154	64,268,031	

¹Total 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.

²On 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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Board of Directors Meeting October October 1, 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

- Medical records have been reviewed, validated and submitted to Centers for Medicare & Medicaid (CMS). Awaiting review and audit results from CMS.

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.

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 Part 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.

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. 2026 Department of Health Care Services (DHCS) PACE Audit

Update

- Awaiting Final Audit Report. Remediation underway.

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.

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.

d. Annual Compliance Program Effectiveness (CPE) Audit (applicable to OneCare)

Update

- Audit engagement letter received on 8/24/26.
- Pre-audit deliverables are due by 9/15/26.

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

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.

e. **Calendar Year (CY) 2024 Part C Risk Adjustment Data Validation (RADV) Audit (CON24 RADV) (applicable to OneCare)**

Update

- 8/28/26 – Contract selection notification received.
- Below are the key dates for the audit:
 - Enrollee Data List Available: 9/11/26
 - Medical record submission window Opens: 9/18/26
 - Medical record submission deadline: 2/5/26
 - Hardship exception request deadline: 2/19/26

Background

- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2024 risk adjustment data and payments associated with encounters with dates of service from January 1, 2013, through December 31, 2013.

2. **Medi-Cal**

a. **2026 Department of Health Care Services (DHCS) Annual Routine Medical Audit**

Update

- 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.
- CalOptima Health’s 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.

B. REGULATORY NOTICES OF NON-COMPLIANCE

- CalOptima Health did not receive any notices of non-compliance from its regulators in August 2026.

C. UPDATES ON HEALTH NETWORK MONITORING AND AUDITS

- 2026 Delegation Oversight Annual Audit (DOAA):
 - No Delegation Oversight Annual Audits to report for the month of August 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 (Medi-Cal)
- 2026 Case Management (OneCare)

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

d. Grants Reviews In Process

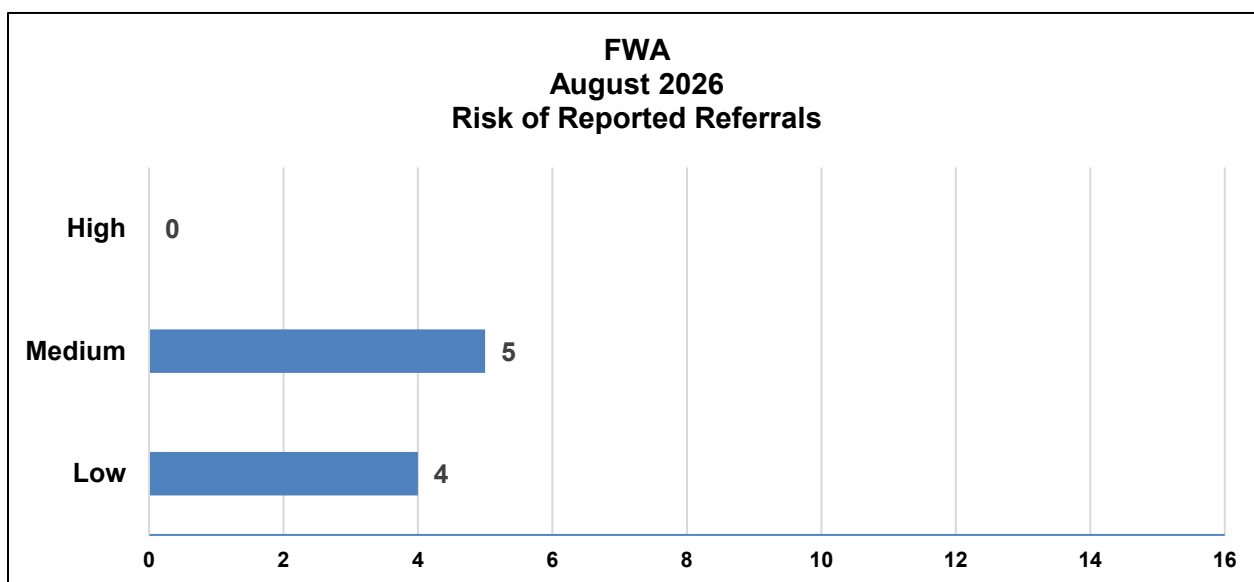
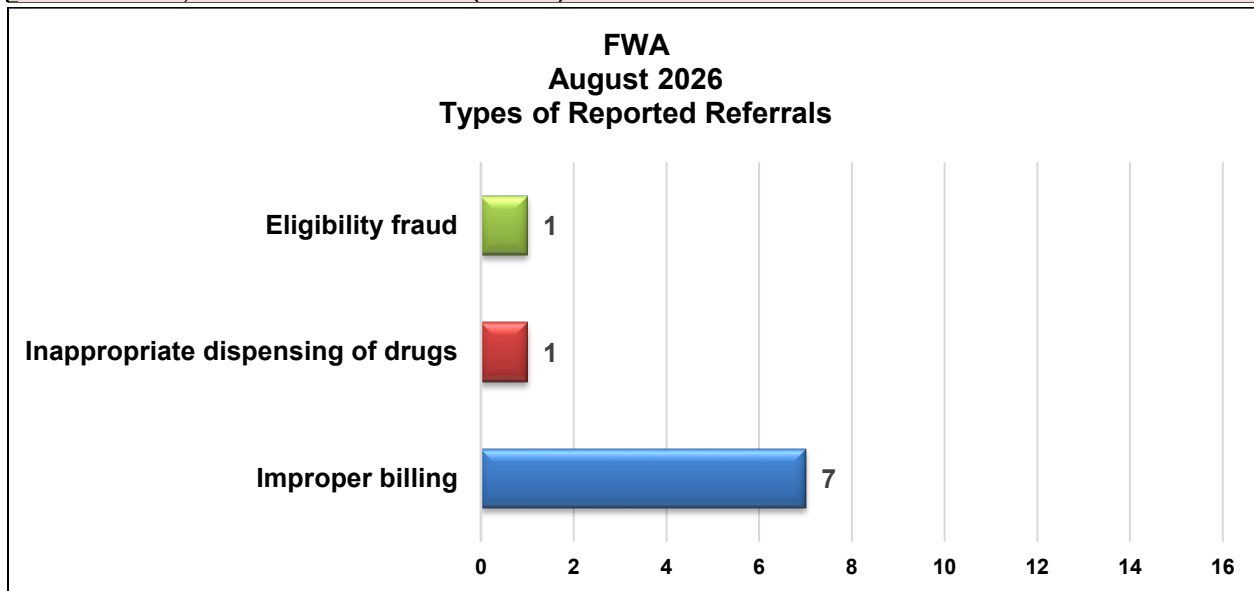
- Mind OC Irvine Hub Campus (Non-Cal AIM grant)
- Dayle McIntosh Center (2023 Incentive Payment Program (IPP) Grant Program)
- Children's Hospital Los Angeles (2023 ECM Academy Cohort 2 Grant)
- Maximon Behavioral Health, dba Mindful Living Center LLC (2023 ECM Academy Cohort 2 Grant)
- Global Transitional Care, Inc. dba Care Partners (2023 ECM Academy Cohort 2 Grant)

e. Grants 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 (Housing and Homelessness Incentive Program (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)

E. FRAUD, WASTE & ABUSE (FWA) INVESTIGATIONS

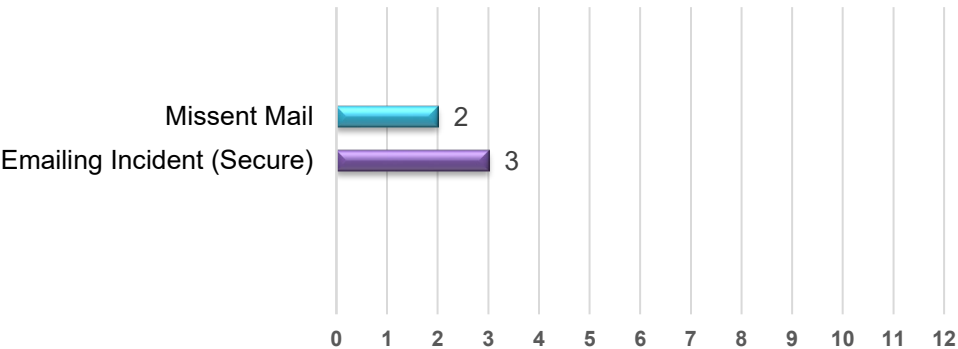


Number of New Cases Referred to DHCS and DOJ (State)	9
Number of New Cases Referred to CMS (Federal)	4

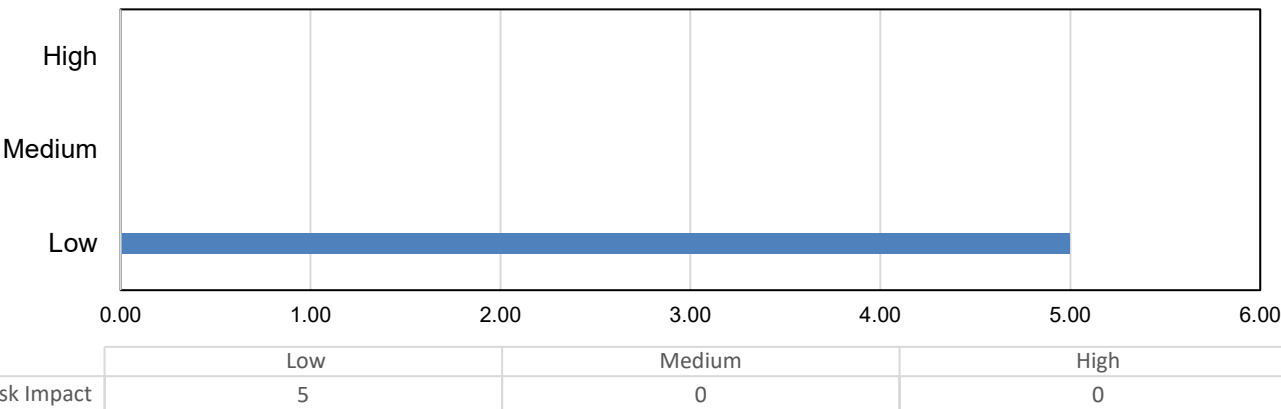
Total Number of Referrals Reported	9
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F. PRIVACY UPDATE

HIPAA Privacy
August 2026
Types of Reported Referrals



HIPAA Privacy
August 2026
Risk of Reported Referrals



Total Number of Referrals Reported to DHCS (State)	5
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0



Date: September 22, 2026

To: Board of Directors
CalOptima Health

From: Shawn Friesen, Vice President
Van Scoyoc Associates

Re: CalOptima Health, Board of Directors – October Advocacy Report

Outreach to Orange County Delegation and California Senators Continues

Van Scoyoc Associates (VSA) continued to be in regular communication with California's U.S. Senators and the Orange County delegation to Congress on behalf of CalOptima Health. VSA was in contact regarding CalOptima Health's advocacy priorities, organizational initiatives, and federal policy developments affecting Medi-Cal and the members CalOptima Health serves. Offices contacted included Senators Alex Padilla (D-CA) and Adam Schiff (D-CA), and Representatives Linda Sánchez (D-CA-38), Young Kim (R-CA-40), Derek Tran (D-CA-45), Lou Correa (D-CA-46), Dave Min (D-CA-47), and Mike Levin (D-CA-49). VSA also has been coordinating with congressional offices to plan in-person visits between CalOptima Health and delegation offices from September 29 through October 1—when CalOptima Health team members will be in Washington, D.C. for association meetings.

Advocacy Efforts Beyond Orange County Continue

VSA also continues to engage with congressional offices outside the Orange County delegation to broaden awareness of CalOptima Health and its programs while also communicating its advocacy priorities and building strategic partnerships around shared advocacy concerns and goals in Medicaid, health care, and federal funding policy. Outreach outside Orange County included the offices of Representatives Vince Fong (R-CA-20), David Valadao (R-CA-22), Pete Aguilar (D-CA-33), Ken Calvert (R-CA-41), and Robert Garcia (D-CA-42). Reps. Calvert and Garcia do not currently represent Orange County, but portions of Orange County are included in the newly drawn districts in which they are running this fall. If Reps. Calvert and Garcia prevail in their fall elections, they would become part of the county's delegation in the next Congress.

VSA to Meet with Center for Medicaid and CHIP Services

As of this writing, VSA Vice President Shawn Friesen is scheduled to meet with senior leadership at the Center for Medicaid and CHIP Services (CMCS) on September 25. CMCS sits under the Centers for Medicare & Medicaid Services (CMS) and is responsible for oversight of all federal Medicaid and Children's Health Insurance Program policy. While Executive Branch officials' ability to comment can be limited at times, the meeting will provide an opportunity to seek updates on the implementation of Medicaid policy changes, the Administration's approach to Medicaid waivers, and other Medicaid policy developments.

Federal Focus on Program Integrity and Addressing Fraud Continues; OIG Releases Report on California

The U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) issued a [report](#) finding that California should have reported Medicaid overpayments totaling \$231.2 million, including a \$99.3 million federal share, identified through 26 Medicaid Fraud Control Unit cases in Federal Fiscal Year 2023. OIG recommended that California return specified federal funds and improve coordination, reporting, and procedures. California agreed with three of the four recommendations but disputed part of OIG's calculation and stated that the Department of Health Care Services



would work with OIG to determine the final amount. The audit is part of a broader HHS OIG effort to identify fraud and examine states' administration of their Medicaid programs. While much attention has been paid to California by the Administration and the press, the HHS OIG's efforts include states around the country and are not limited to California.

CMS Provides More Detail on Medical Frailty Exclusion, Offers Suggested Tiered Process

CMS released a [slide deck](#) to provide states with guidance as they seek to implement the medical frailty exclusion from the community engagement requirements, or work requirements, that will now be required under [H.R. 1](#) starting January 1, 2027. The exclusion was outlined under the recent interim final rule (IFR), and CMS has emphasized that states may not extend the exclusion beyond the five categories included in H.R. 1 and that an individual must have a condition that significantly impairs their ability to comply with the requirements. In the slides, CMS offers a suggested, but not required, three-tier process under which states may use available health data to identify individuals who clearly qualify, seek additional information where the data is inconclusive, and conduct individualized reviews when necessary.

House Democratic Doctors Express Concern to CMS about Medical Frailty Standard, Burden on Providers

The House Democratic Doctors Caucus wrote to CMS Administrator Mehmet Oz regarding the medical frailty standard for the community engagement or work requirements under H.R. 1, making the case that the IFR released on June 1 exceeds the statute and would impose additional documentation burdens on providers. States challenging the IFR have narrowed their case to focus on the medical frailty standard, with a hearing scheduled for October 20. CMS also said it will review relevant issues raised in more than 44,000 public comments and generally address significant issues in subsequent rulemaking. For CalOptima Health and its providers, the central operational questions remain how California will use available data, when individualized clinical documentation will be required, and how the state will limit the loss of coverage for eligible individuals as implementation approaches.

CMS Review of Section 1115 Waivers Draws Attention; CalAIM Waiver up in December

With new requirements under H.R. 1, CMS's review of states' Section 1115 demonstration renewal requests is being closely watched. CMS has approved a limited number of renewals under the current Administration, and the agency has granted multiple temporary extensions to states with otherwise expiring waivers. The temporary extensions have ranged from three to 15 months, and CMS has generally granted extensions with the purpose of allowing for continued negotiations as the states work to update their waivers. This summer, CMS told Arkansas that it would not approve the state's waiver renewal as submitted, and Arkansas has requested a two-year extension of its current waiver so the state can have additional time to develop a revised approach. [California's 1115 waiver](#), which serves as the backing and construct for CalAIM, is set to expire on December 31 of this year, and the [CalAIM renewal application](#) is pending before the agency. CMS's actions toward other states should not be seen as determinative for California, but they do indicate that CMS is giving more scrutiny to budget neutrality in the Medicaid program—particularly as it pertains to health-related social needs services, delivery system reforms, and other initiatives that extend beyond traditional Medicaid coverage. The new requirement for CMS Chief Actuary certification of Section 1115 budget neutrality takes effect January 1, 2027, making the timing and terms of California's renewal particularly important.

Congress Recesses with Year-End Health Negotiations Still Ahead

On September 2, the President signed legislation ([H.R. 6500](#)), also often referred to as a continuing resolution (CR), to fund the federal government through December 11 and temporarily extend the funding for several health programs that was set to expire at the end of September. The House has recessed until November 9, and both the House and Senate will be out for much of October before the elections. Congress will return to a compressed year-end agenda that includes Fiscal Year 2027 appropriations to fund federal government departments and agencies as well as discussions about a larger health package that could include longer-term extensions of funding for several health programs and a larger number of bipartisan proposals. The Ways and Means Committee did not include legislation to amend the No Surprises Act in its September markup after members failed to reach an agreement. VSA will continue monitoring negotiations related to



Medicaid, Medicare, community health center funding, and other health provisions that could move during the lame-duck session.

Ways and Means Advances Bills Promoting Medically Tailored Meals, Improving Medicare Data

On September 16, the House Ways and Means Committee [advanced](#) three bipartisan health bills of relevance to CalOptima Health and its programs. In a 39-0 vote, the Committee approved the Medically Tailored Home-Delivered Meals Program Pilot Act ([H.R. 5439](#)), which would establish a Medicare pilot involving at least 40 eligible hospitals to provide medically tailored home-delivered meals to qualifying beneficiaries after discharge. The panel also reported out the Apples to Apples Comparison Act ([H.R. 4093](#)) in a 25-15 vote. The bill would require more detailed Medicare enrollment and expenditure information by county and metropolitan area and direct the Medicare Payment Advisory Commission to account for benefit and beneficiary differences when comparing Medicare Advantage and traditional Medicare. In addition, the Committee approved the Alzheimer's Screening and Prevention Act ([H.R. 6130](#)) in a 40-0 vote. The bill would expand Medicare coverage of certain early-detection services during annual wellness visits. The bills now await possible House consideration and could also be considered for inclusion in a larger year-end health package.

Senate Committees Consider HHS Leadership and Other Health Nominees

The [Senate Finance Committee](#) heard testimony and considered Chris Klomp's nomination to be Deputy Secretary of Health and Human Services, with discussion touching on department management, prescription drug policy, vaccines, and public health. The Senate Health, Education, Labor, and Pensions (HELP) Committee also [held hearings](#) on President Trump's health nominees, including Klomp's nomination as well as the nominations of Nicole Saphier to be Surgeon General and Timothy Westlake to be Assistant Secretary for Mental Health and Substance Use. As of this writing, HELP is scheduled to [vote September 24](#) on the Saphier and Westlake nominations and to hold a hearing that same day on [Heidi Overton's nomination](#) to be Commissioner of the Food and Drug Administration. The timing of Senate consideration and action on the nominations remains uncertain.

House Democrats Begin Developing Health Care Agenda

House Democrats' Cost of Living Healthcare Working Group, co-convened by Reps. Alexandria Ocasio-Cortez (D-NY) and Terri Sewell (D-AL), sent House Minority Leader Hakeem Jeffries (D-NY) a report compiling health policy proposals from across the caucus. The options include Medicare for All, adding dental, vision, and hearing benefits to Medicare, capping certain out-of-pocket costs, and addressing health care workforce shortages. House Democrats reportedly have broader agreement around restoring the enhanced Affordable Care Act premium tax credits, reversing Medicaid and Affordable Care Act policy changes enacted under H.R. 1, and lowering prescription drug costs, but the caucus has not reached consensus on a longer-term coverage approach. The report offers an early indication of health policy priorities House Democrats may pursue if they regain the majority in the next Congress.

MACPAC Meeting to Focus on Community Engagement and Medicaid Financing

The Medicaid and CHIP Payment and Access Commission (MACPAC) is scheduled to meet on September 24 and 25. The [agenda](#) includes two sessions on the Medicaid community engagement requirements: a review of the interim final rule and a proposed monitoring framework, followed by an expert panel with representatives from the National Association of Medicaid Directors and Health Management Associates. Commissioners also will review the proposed rules addressing state directed payments and health care-related taxes—both central implementation issues under H.R. 1. Other sessions will address utilization management for medications for opioid use disorder, children and youth in foster care enrolled in Medicaid managed care, beneficiary health and welfare in self-directed home- and community-based services, and Medicaid coverage of assistive technology for adults. VSA will monitor the meeting for discussion of these issues and for any implications of the community engagement and financing sessions for CalOptima Health.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT

September 22, 2026

General Update

The Legislature's constitutional deadline to pass bills for the year was August 31, but lawmakers returned for one additional day on September 1 in a last-ditch effort to pass a wildfire liability and insurance package (SB 492). That effort ultimately died without a vote after weeks of closed-door negotiations among the Governor, utilities, insurers, and fire survivor advocates collapsed. Its failure has prompted speculation that Governor Newsom could call a special session this fall to revisit the issue.

With lawmakers now back in their districts, attention in Sacramento has shifted to Governor Newsom, who has until September 30 to sign or veto legislation sent to his desk. The Governor has already begun acting on bills in batches, with the pace of signings and vetoes expected to accelerate as the deadline approaches.

For legislators, the fall recess also marks a shift toward district and political activity. Members are closely watching the Governor's actions on their priority bills, while many are increasingly turning their attention to the November 3 election. All 80 Assembly seats and 20 of the 40 Senate seats are on the ballot, along with the race to succeed Governor Newsom.

The election will also begin to shape the next legislative session. In addition to changes in legislative membership and committee leadership, a new gubernatorial administration will take office in January, bringing new leadership, appointments and policy priorities throughout state government. Healthcare stakeholders will be watching closely for potential changes at agencies, including DHCS, and for how the incoming administration approaches the implementation of significant Medi-Cal eligibility, financing and delivery-system changes scheduled to take effect in 2027.

Budget Update

Governor Newsom signed a final package of Fiscal Year 2026–27 budget legislation on September 18, including AB 113, which makes additional adjustments to the Budget Act, and AB 173, the health budget trailer bill. The measures largely address implementation, technical and remaining policy issues and do not materially alter the major Medi-Cal decisions enacted as part of the June budget agreement.

Of particular relevance to Medi-Cal, AB 173 expands DHCS oversight of Medi-Cal providers, including additional authority related to provider enrollment and affiliations associated with potential fraud, waste or abuse. The bill also establishes a state-only program to provide medically necessary outpatient dialysis to restricted-scope Medi-Cal beneficiaries beginning October 1, 2026, along with several changes to the state's 988 behavioral health crisis system.

Separately, a September 16 Legislative Analyst's Office (LAO) report highlighted an unusual disconnect in the state's finances. California had approximately \$86 billion in available cash as of June 30, despite continuing General Fund deficits. Much of that money has already been committed but not yet spent, and the LAO cautioned that the large cash balance does not mean the state's overall fiscal condition is strong.

Of particular relevance to Medi-Cal, the state used \$3.4 billion in available cash to cover higher-than-expected Medi-Cal costs, while delaying when those costs are counted against the state budget. The obligation will instead be recognized over several years through 2034. The LAO cautioned against relying too heavily on this type of internal borrowing to manage ongoing budget deficits. The LAO report can be accessed [HERE](#).

The major budget policies affecting CalOptima Health remain unchanged, including the transition of undocumented adults to Medi-Cal fee-for-service on January 1, 2027; the implementation of monthly premiums for that population on July 1, 2027; changes to the MCO tax; and other Medi-Cal eligibility and benefit changes. Attention is now shifting almost entirely to implementation as DHCS and Medi-Cal managed care plans prepare for significant eligibility, financing and delivery-system changes scheduled throughout 2027.

Looking ahead, anticipated increases in the undocumented population and the resulting pressure on county indigent health programs are expected to reemerge as significant issues in the next 2027–28 State Budget.

Key Legislation Updates

PACE Rate-Setting Transparency – AB 1672 (Solache-D) – CalPACE-sponsored legislation that would increase transparency in DHCS’s PACE rate-setting process. The bill was placed on the Senate inactive file and was not brought up for a final vote, killing the bill for the 2025-26 session.

Medi-Cal: Special Commissions – AB 2194 (Valencia-D) – Originally sponsored by the County of Orange, AB 2194 makes several changes to CalOptima Health’s governance structure. After undergoing significant revisions during the legislative process, the final bill retains the existing role of the Orange County Board of Supervisors and establishes staggered terms for CalOptima Health Board members. Three members will initially receive two-year terms followed by four-year terms, with those members permitted an additional four-year term so they are not disadvantaged by the initial shortened term. The bill also requires CalOptima Health to commission an independent audit of its governance policies and practices.

AB 2194 passed the Senate and Assembly unanimously and is now awaiting action by Governor Newsom by September 30. Assemblymember Valencia has indicated that he intends to continue examining CalOptima Health’s governance structure, particularly the role of the Orange County Board of Supervisors, suggesting the issue could return in the 2027–28 Legislative Session.

Proposition Update

2026 Billionaire Tax Act (Proposition 40) – Proposition 40 would impose a one-time 5% tax on individuals and trusts with covered assets exceeding \$1 billion, with 90% of revenues dedicated to healthcare and 10% to food assistance or education-related programs. The LAO estimates the measure would generate tens of billions of dollars over several years, while potentially reducing ongoing state income tax revenues by hundreds of millions of dollars or more annually.

The campaign has become one of the most heavily financed and politically contested measures on the November ballot. Building a Better California, an opposition group co-founded by Google's Sergey Brin, had raised roughly \$118 million by August, with Brin alone contributing over \$100 million; additional contributions from figures including venture capitalist John Doerr and Ripple co-founder Chris Larsen have continued to grow the group's war chest, which by mid-August had topped \$127 million across its opposition to Proposition 40 and its sponsorship of the two competing measures, Propositions 41 and 42. Proposition 40 has also divided traditional Democratic, labor and healthcare allies. The California Democratic Party narrowly endorsed the measure at its August convention, breaking with Governor Gavin Newsom, gubernatorial candidate Xavier Becerra, the California Teachers Association, the California Medical Association (CMA) and the California Primary Care Association (CPCA), all of whom remain opposed.

Polling remains close but has tightened in favor of Proposition 40. A PPIC survey released September 15–16 found 52% of likely voters would vote yes on Proposition 40 and 46% would vote no, with the remainder undecided. The same survey found competing Propositions 41 and 42 also drawing majority or near-majority support, with 51% for Proposition 41 and Proposition 42 similarly ahead, underscoring the risk that Proposition 40 could win a majority of the vote yet still be nullified if either competing measure outpolls it.

Clinic Funding Accountability and Transparency Act (Proposition 44) – Proposition 44 would require nonprofit Federally Qualified Health Centers (FQHCs) to spend at least 90% of revenue on patient care and other qualifying program services and would impose new reporting and enforcement requirements. SEIU-UHW argues the measure would increase accountability and direct more resources toward patient care, while opponents, including CPCA, CMA and other healthcare organizations, contend the requirements could financially destabilize community clinics and reduce access to care.

In August, a federal judge dismissed an earlier lawsuit filed by CPCA and Open Door Community Health Centers seeking to prevent Proposition 44 from appearing on the November ballot, finding the challenge premature because the measure had not yet been approved or implemented.

On September 18, CPCA and five community health centers filed a separate federal lawsuit against SEIU-UHW and its president, Dave Regan, alleging racketeering and improper use of the ballot initiative process to pressure clinics into accepting union-organizing terms. The lawsuit alleges that the union offered to withdraw Proposition 44 if community clinics agreed to facilitate union elections covering 25,000 employees over five years. SEIU-UHW and Regan have denied that Proposition 44 was used improperly to obtain organizing concessions. The litigation highlights the longstanding labor dispute underlying the Proposition 44 campaign.

Recent polling shows Proposition 44 facing significant opposition among voters. A September PPIC survey found that 34% of likely voters supported the measure and 61% opposed it. The campaign has also become heavily financed on both sides. According to California Secretary of State filings, the "Yes on Prop 44" committee, sponsored by SEIU-UHW, has reported approximately \$16.9 million in contributions, while the "No on Prop 44" committee, sponsored by CPCA Advocates, has reported approximately \$34.9 million, making opposition spending roughly double that of the union-backed support campaign.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
<u>SB 483</u> 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
<u>SB 490</u> Umberg	Alcohol and Drug Programs: Would implement specific timelines for the California Department of Health Care Services (DHCS) to investigate unlicensed treatment facilities (i.e., sober living homes) that were unlawfully advertising or providing services. Potential CalOptima Health Impact: Increased oversight of treatment facilities that serve CalOptima Health members.	08/27/2026 Senate concurred in amendments; ordered to the Governor 08/25/2026 Passed Assembly floor 01/26/2026 Passed Senate floor	CalOptima Health: Watch
<u>SB 626</u> Smallwood-Cuevas	Maternal Mental Health Screenings and Treatment: Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. Potential CalOptima Health Impact: Increased access to behavioral health services for eligible members.	08/28/2026 Senate concurred in amendments; ordered to the Governor 08/25/2026 Passed Assembly floor 06/02/2025 Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>SB 812</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 874</u> Weber-Pierson	Behavioral Health Treatment (BHT) Workgroup: Would require any provider of BHT services under Medi-Cal to complete criminal background checks. Additionally, would require DHCS to use existing stakeholder forums to review the implementation of BHT services in Medi-Cal and release clinical guidance and treatment plan requirements. <i>Potential CalOptima Health Impact:</i> Enhanced oversight and quality of BHT services provided to members under 21 years of age with autism spectrum disorder and/or related conditions.	08/24/2026 Senate concurred in amendments; ordered to the Governor 08/20/2026 Passed Assembly floor 05/19/2026 Passed Senate floor	CalOptima Health: Watch
<u>AB 37</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 348</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 384</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 423</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 618</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 877</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 951</u> 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. <i>Potential CalOptima Health Impact:</i> Increased access to care for specific behavioral health treatments.	07/30/2025 Signed into law	CalOptima Health: Watch
<u>AB 1970</u> 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. <i>Potential CalOptima Health Impact:</i> 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			
<u>H.R. 1</u> 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	<u>05/20/2025</u> CalOptima Health: OPPOSE

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>H.R. 7148</u> 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
<u>SB 101</u> Wiener <u>AB 102</u> 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
<u>SB 106</u> 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
<u>SB 111</u> Laird <u>AB 109</u> 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
<u>SB 125</u> 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). <i>Potential CalOptima Health Impact:</i> An overview of the FY 2026–27 Enacted State Budget is enclosed.	06/29/2026 Signed into law	CalOptima Health: Watch
<u>SB 164</u> 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. <i>Potential CalOptima Health Impact:</i> An overview of the FY 2026–27 Enacted State Budget is enclosed.	06/29/2026 Signed into law	CalOptima Health: Watch
<u>AB 100</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 113</u> 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
<u>AB 116</u> 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
<u>AB 144</u> 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 <i>Potential CalOptima Health Impact:</i> An overview of the FY 2025–26 Enacted State Budget is enclosed.	09/17/2025 Signed into law	CalOptima Health: Watch

<u>AB 173</u> 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: ○ 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). ○ Temporarily suspend providers under investigation for FWA and make suspensions effective more quickly. ○ Impose provider enrollment moratoria, including removing existing exemptions for certain clinics and health professionals.	09/18/2026 Signed into law	CalOptima Health: Watch
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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)			
<u>SB 324</u> 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
<u>AB 543</u> 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
<u>AB 2138</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 2348</u> Bonta	Community Supports Extension: Would extend Community Supports within the Medi-Cal managed care program — by proposing that the supports are deemed cost-effective and medically appropriate services — beyond the existing CalAIM initiative, beginning January 1, 2027. Additionally, would implement quarterly public reporting on Community Supports utilization with ongoing technical assistance. <i>Potential CalOptima Health Impact:</i> Safeguards access to Community Supports for Medi-Cal members.	08/25/2026 Assembly concurred in amendments; ordered to the Governor 08/24/2026 Passed Senate floor 05/24/2026 Passed Assembly floor	CalOptima Health: Watch
Covered Benefits			
<u>SB 40</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 62</u> Menjivar <u>AB 224</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 535</u> Richardson <u>AB 575</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 912</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 944</u> Wiener	Acupuncture Coverage: Would subject Medi-Cal coverage of acupuncture to utilization controls and the availability of federal financial participation. If federal financial participation is not available, coverage would be subject to appropriation by the Legislature. <i>Potential CalOptima Health Impact:</i> Maintained covered benefits for members.	08/28/2026 Senate concurred in amendments; ordered to the Governor 08/25/2026 Passed Assembly floor 05/19/2026 Passed Senate floor	CalOptima Health: Watch
<u>AB 242</u> Boerner	Genetic Disease Screening: Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 298</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 350</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 432</u> 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. <i>Potential CalOptima Health Impact:</i> New covered benefits for members; increased communications to providers.	10/13/2025 Vetoed	CalOptima Health: Watch CAHP: Oppose
<u>AB 636</u> 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 <i>Potential CalOptima Health Impact:</i> 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
<u>AB 1949</u> Lee	Acupuncture Treatment Flexibility: Subject to federal financial participation, would require Medi-Cal coverage of up to 24 acupuncture visits per beneficiary per calendar year. Additional visits per year could be authorized based on medical necessity. <i>Potential CalOptima Health Impact:</i> Expanded covered benefit for members.	08/26/2026 Assembly concurred in amendments; ordered to the Governor 08/25/2026 Passed Senate floor 05/26/2026 Passed Assembly floor	CalOptima Health: Watch
<u>AB 2160</u> Celeste Rodriguez	Lactation Services: Would require DHCS to update Medi-Cal's coverage guidance on lactation services by July 1, 2027, to clarify coverage policies for various lactation services, including health education, support and consultation. <i>Potential CalOptima Health Impact:</i> Expanded access to lactation services for members.	08/24/2026 Assembly concurred in amendments; ordered to the Governor 08/20/2026 Passed Senate floor 05/26/2026 Passed Assembly floor	CalOptima Health: Watch
<u>AB 2208</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 2240</u> 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. <i>Potential CalOptima Health Impact:</i> 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			
<u>SB 1202</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 1422</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 315</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 974</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 1012</u> 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. <i>Potential CalOptima Health Impact:</i> Decreased number of members.	01/31/2026 Died at Assembly desk 02/21/2025 Introduced	CalOptima Health: Watch
<u>AB 1161</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 1907</u> 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. <i>Potential CalOptima Health Impact:</i> Increased enrollment in future Covered California line of business; streamlined enrollment process for certain members.	09/15/2026 Signed into law	CalOptima Health: Watch
<u>AB 2161</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 2201</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 2363</u> 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. <i>Potential CalOptima Health Impact:</i> Reduced financial penalties for certain current and future members.	02/202026 Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
Medi-Cal Operations and Administration			
<u>SB 278</u> 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. <i>Potential CalOptima Health Impact:</i> Increased quality oversight of HIV program development.	10/13/2025 Signed into law	CalOptima Health: Watch
<u>SB 497</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 530</u> 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. <i>Potential CalOptima Health Impact:</i> Increased oversight of contracted providers; increased reporting to DHCS.	10/06/2025 Signed into law	CalOptima Health: Watch
<u>SB 660</u> 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. <i>Potential CalOptima Health Impact:</i> Increased care coordination with social service providers.	10/03/2025 Signed into law	CalOptima Health: Watch
<u>SB 987</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 45</u> 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. <i>Potential CalOptima Health Impact:</i> Increased safeguards regarding reproductive health information.	09/26/2025 Signed into law	CalOptima Health: Watch
<u>AB 257</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 316</u> 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. <i>Potential CalOptima Health Impact:</i> Increased liability related to UM procedures.	10/13/2025 Signed into law	CalOptima Health: Watch
<u>AB 403</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 577</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 688</u> 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. <i>Potential CalOptima Health Impact:</i> New reporting requirements to DHCS.	10/07/2025 Signed into law	CalOptima Health: Watch
<u>AB 980</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 2194</u> Valencia	CalOptima Health Governance: Would implement staggered terms on the CalOptima Health Board of Directors (Board), effective for the new terms expected to begin in August 2028. To accommodate a transition, the following three Board seats would serve initial two-year terms 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, would require 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 Orange County Health Care Agency's nomination process for Board members. <i>Potential CalOptima Health Impact:</i> Increased continuity of Board representation; increased staff workload to initiate and respond to independent external audit	08/26/2026 Assembly concurred in amendments; ordered to the Governor 08/24/2026 Passed Senate floor 04/16/2026 Passed Assembly floor	<u>08/06/2026</u> CalOptima Health: NEUTRAL
<u>AB 2565</u> Wallis	Pharmacist Services: Would require DHCS to update its model evidence of coverage (EOC) to explicitly include the obligation of MCPs to cover pharmacist services. <i>Potential CalOptima Health Impact:</i> Updated member-facing materials, such as EOCs and member handbooks.	08/20/2026 Passed Senate floor; ordered to the Governor 05/14/2026 Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
<u>SB 242</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 412</u> 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. <i>Potential CalOptima Health Impact:</i> New training requirements for PACE staff.	10/06/2025 Signed into law	CalOptima Health: Watch
Providers			
<u>SB 32</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 250</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 306</u> 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
<u>SB 504</u> 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
<u>SB 1049</u> Pierson	Claim Reimbursements: Would grant 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, would prohibit 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.	08/24/2026 Senate concurred in amendments; ordered to the Governor 08/20/2026 Passed Assembly floor; 05/19/2026 Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
<u>AB 29</u> 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
<u>AB 50</u> 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. <i>Potential CalOptima Health Impact:</i> Increased member access to hormonal contraceptives.	09/26/2025 Signed into law	CalOptima Health: Watch
<u>AB 55</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 220</u> Jackson	Medi-Cal Subacute Care Authorization: Would require a provider seeking prior authorization for pediatric subacute or adult subacute care services under the Medi-Cal program to submit a specified form. Additionally, would prohibit a Medi-Cal MCP from developing or using its own criteria for medical necessity and from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. <i>Potential CalOptima Health Impact:</i> Modified UM procedures and forms.	08/30/2026 Assembly concurred in amendments; ordered to the Governor 08/30/2026 Amended and re-passed Senate floor 09/04/2025 Passed Senate floor 05/29/2025 Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 280</u> Aguiar-Curry	Provider Directory Accuracy: Would require 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, would require the provider to be reimbursed at the agreed-upon or otherwise reasonable amount without the patient incurring charges beyond in-network cost-sharing amounts. Would also require that, within 30 days of receiving a request from a health plan, a provider must confirm that its information is current and accurate or update the required information. <i>Potential CalOptima Health Impact:</i> In future Covered California line of business, modified processes for managing provider directory; increased coordination with providers.	07/09/2025 Passed Senate Health Committee; referred to Senate Appropriations Committee 06/02/2025 Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
<u>AB 375</u> Nguyen	Qualified Autism Service Paraprofessional: Would expand the definition of “health care provider” to also include a qualified autism service paraprofessional. <i>Potential CalOptima Health Impact:</i> Increased access to autism services for eligible members; additional provider contracting and credentialing.	08/25/2026 Assembly concurred in amendments; ordered to the Governor 08/20/2026 Passed Senate floor 01/29/2026 Passed Assembly floor	CalOptima Health: Watch
<u>AB 416</u> 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. <i>Potential CalOptima Health Impact:</i> New legal standards for certain CalOptima Health providers.	10/13/2025 Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 510</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 512</u> 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 <i>urgent</i> requests and three business days via electronic submission or five business days via non-electronic submission for <i>standard</i> requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 517</u> 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. <i>Potential CalOptima Health Impact:</i> Modified UM procedures for a covered Medi-Cal benefit.	01/23/2026 Died in Assembly Appropriations Committee 04/08/2025 Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 539</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 787</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 1041</u> 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. <i>Potential CalOptima Health Impact:</i> 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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 1843</u> Elhawary	Communicable Disease: Would prohibit health plans from requiring authorization for direct-acting antiviral drugs needed for hepatitis C treatment. Potential CalOptima Health Impact: Modified UM procedures.	08/30/2026 Assembly concurred in amendments; ordered to the Governor 08/30/2026 Passed Senate floor 05/21/2026 Passed Assembly floor	CalOptima Health: Watch
<u>AB 1887</u> Zbur	Prescription Drug Coverage for Rare Diseases: Would require 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.	08/30/2026 Assembly concurred in amendments; ordered to the Governor 08/30/2026 Passed Senate floor 05/27/2026 Passed Assembly floor	CalOptima Health: Watch
<u>AB 2352</u> 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
<u>AB 2457</u> 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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Rates & Financing			
<u>SB 339</u> Cabaldon	Medi-Cal Laboratory Rates: Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to <i>equal</i> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 1672</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 2036</u> 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. <i>Potential CalOptima Health Impact:</i> 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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 2327</u> 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. <i>Potential CalOptima Health Impact:</i> 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: September 21, 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	



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
<u>Unsatisfactory Immigration Status (UIS)-Member Impacts</u>
Freeze on <i>new</i> 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; <i>currently enrolled</i> 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
<u>All-Member Impacts</u>
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.



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:

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.

- 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.

- 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.



CalOptima Health Community Outreach Summary — September and October 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

Community Relations Supports Members Through Medi-Cal Changes

CalOptima Health's Community Relations Department is proactively supporting members and the community in navigating changes to programs and services by partnering with the Orange County Social Services Agency and community-based organizations to provide timely presentations and information about available programs and resources. These efforts also connect community members with trusted community partners and enrollment assistance to help them access the support they need.

The team is collaborating with internal departments, including Community Health, Strategic Development and Communications, to support the distribution of accurate and consistent information to members and the community. Additional outreach includes providing updates and presentations through Community Connections, as well as planning town halls with local school districts and other community stakeholders. These town halls will provide information and connections to community resources to help individuals and families understand the new requirements and identify available support to meet them.

Summary of Public Activities

As of September 9, CalOptima Health will participate in, organize or convene 86 public activities in September and October. In September, there were 50 public activities, including 12 community/collaborative meetings, 33 community events, four community-based presentations, and one Health Network Forum.

In October, there will be 36 public activities, including 13 community/collaborative meetings, 20 community events, one community-based presentation, one Community Connections Meeting, and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided 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 Orangewood Foundation's Proposal to County of Orange for Resource and Support Services for Commercially Sexually Exploited Children

For additional information or questions, contact CalOptima Health Executive Director Deanne Thompson at 714-954-2141 or deanne.thompson@caloptima.org.

Community Events Hosted by CalOptima Health and Community Partners in September and October 2026:

September 2026



September 2, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Garfield Elementary School, 850 Brown St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community



September 2, 4–6 p.m., Garden Grove Unified School District Back-to-School, hosted by the Garden Grove Unified School District and the County of Orange Social Services Agency

Los Amigos High School, 16566 Newhope St., Fountain Valley

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 2, 4:30–6 p.m., Back-to-School Night Resource Fair, hosted by Magnolia High School

Magnolia High School, 240 W. Ball Rd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 3, 4:30–6 p.m., Back-to-School Night Resource Fair, hosted by Anaheim High School

Edgar Erwood Elementary School, 6202 Cerulean Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 4, 9:45 a.m.–1:40 p.m., Resource Fair for School Community Liaison Training, hosted by the Garden Grove Unified School District

Anaheim High School, 811 W. Lincoln Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 5, 8 a.m.–Noon, Community Yard Sale and Resource Fair, hosted by the City of Tustin

Tustin Civic Center, 300 Centennial Way, Tustin

- Registration fee: \$25; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 8, 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



September 9, 2:30–4 p.m., CalOptima Health Medi-Cal Overview in English

Boys & Girls Club of Garden Grove, 9860 Larson Av., Garden Grove

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community



September 10, 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



September 12, 9–11 a.m., Health and Safety Fair, hosted by the City of Aliso Viejo

Aliso Viejo Ranch, 100 Park Ave., Aliso Viejo

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 12, 10 a.m.–3 p.m., Learn and Grow 2026, hosted by Parenting OC Magazine

The District at Tustin Legacy, 2437 Park Ave., Tustin

- Sponsorship fee: \$1,000; included a resource booth, listing on website and material insert in event bag.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 15, 10 a.m.–1 p.m., Older Adults Fall Health Fair, hosted by the City of Anaheim

Ponderosa Park Family Resource Center, 320 E. Orange Wood Ave., Anaheim

- Registration fee: \$50; included a resource booth.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 15, 10 a.m.–3 p.m., Southern California Healthy Steps Convening, hosted by First 5 Orange County

Embassy Suites Brea, 900 E. Birch St., Brea

- Sponsorship fee: \$5,000; included a resource booth, organization logo on event materials, recognition during opening sessions, a reserved table and option to include materials in participant packets.
- At least two 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



September 15, 4:30–6 p.m., Back-to-School Night, hosted by Brookhurst Junior High School

Brookhurst Junior High School, 601 N. Brookhurst St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 16, 8:30–10 a.m., CalOptima Health Medi-Cal Overview in Spanish

Walter Elementary School, 10802 Rustic Ln., Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community



September 17, 5–6:30 p.m., Back-to-School Night, hosted by Portola Middle School

Portola Middle School, 270 N. Palm Dr., Orange

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 18, 9 a.m. –Noon, Childhood Resource Fair, hosted by the Capistrano Unified School District

Capistrano Unified School District Office, 33122 Valle Rd., San Juan Capistrano

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 19, 9 a.m.–1 p.m., Annual OneCare Wellness and Resource Fair, hosted by CalOptima Health

Delhi Center, 505 E. Central Ave., Santa Ana

- At least 20 staff members attended (in person)
- Health/Resource Fair, open to the public



September 19, 10 a.m.–1 p.m., Active Living Expo, hosted by the Senior Center in Central Park

Senior Center in Central Park, 18041 Goldenwest St., Huntington Beach

- Sponsorship fee: \$1,000; included a resource booth, organization name and logo on city website and event materials, and half a page advertisement in expo brochure.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 19, 10 a.m.–1 p.m., Older Adults Fall Health Fair, hosted by the City of Anaheim

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- Registration fee: \$150; included a resource booth.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 22, 8 a.m.–4 p.m., Nurturing Mental Health in a Digital World, hosted by the Orange County Department of Education

Hilton Costa Mesa, 3050 Bristol St., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 22, 4:30–6 p.m., Back-to-School Night Resource Fair, hosted by Dale Junior High School

Dale Junior High School, 900 S. Dale Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 22 thru 23, 9 a.m.–5 p.m., 2026 Annual Conference, hosted by SoCal Grantmakers

The Westin Bonaventure Hotel and Suites, 404 Figueroa St., Los Angeles

- Sponsorship fee: \$2,500; included a resource booth, one general admission ticket, logo on conference materials, and organization name on conference platforms.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 23, 10 a.m.–Noon, Community Resource Fair, hosted by Equus Workforce Solutions

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 23, 10 a.m.–1 p.m., Older Adult Resource Fair, hosted by H. Louis Lake Senior Center

H. Louis Lake Senior Center, 11300 Stanford Ave., Garden Grove

- Sponsorship fee: \$1,000; included a resource booth.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 23, 5:30 p.m.–7 p.m., Back to School Night, hosted by Gilbert High School

Gilbert High School, 1800 W. Ball Rd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 24, 9:30 a.m.–Noon, Knowledge and Health Fair Expo, hosted by the Costa Mesa Senior Center

Costa Mesa Senior Center, 695 W. 19th St., Costa Mesa

- Registration fee: \$650; included a resource booth, organization logo on event materials, and presentation opportunity.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 24, 10 a.m.–1 p.m., Older Adults Fall Health Fair, hosted by the City of Anaheim

West Anaheim Youth Center, 320 E. Beach Blvd., Anaheim

- Registration fee: \$50; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 24, 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



September 25, 8 a.m.–3 p.m., SoCal Alzheimer's Disease Research Conference, hosted by UCI Mind

Irvine Marriott, 1800 Von Karman Ave., Irvine

- Sponsorship fee: \$3,000; included a resource booth, eight general admission tickets, logo on event website and conference materials.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 25, 9 a.m.–Noon, Healthy Living Expo, hosted by the City of Irvine

Lakeview Senior Center, 20 Lake Rd., Irvine

- Registration fee: \$273; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 25, 9 a.m.–2 p.m., OC 10th Regional Conference, hosted by Visión y Compromiso

Saint Boniface Church, 120 N. Janss St., Anaheim

- Sponsorship fee: \$2,500; included a resource booth, eight general admission tickets, logo on event website and conference materials.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 26, 8:30 a.m.–4 p.m., Teaching, Living, Caring Pathways Conference, hosted by Family Support Network

Santa Ana Elks Lodge, 1601 E. St. Andrew Pl., Santa Ana

- Sponsorship fee: \$2,500; included a resource booth, logo placement across all conference materials and platforms. Featured promotion across social media and communications. Recognition on FSN's website and a speaking opportunity.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 26, 9 a.m.–4 p.m., 2026 BIPOC Community Health Fair, hosted by HEAAL Collective

Delhi Community Center, 505 E. Central Ave., Santa Ana

- Sponsorship fee: \$3,000; included a resource booth and speaking opportunity.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 26, 10 a.m.–1 p.m., Older Adults Fall Health Fair, hosted by City of Anaheim

East Anaheim Community Center, 8201 E. Santa Ana Canyon Rd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 26, 10 a.m.–4 p.m., Dinosaur Train Day, hosted by PBS SoCal Kids

The Children's Museum at La Habra, 301 S. Euclid St., La Habra

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 26, 1–4 p.m., Embrace Aging Expo, hosted by the Westminster Senior Center

Westminster Senior Center, 8200 Westminster Blvd., Westminster

- Sponsorship fee: \$650; included a double resource booth space, organization name in event program and city website and listed as sponsor on marketing materials. Additionally, an opportunity to host a presentation at a later date.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 29, 8:30–10 a.m., CalOptima Health Medi-Cal Overview in English and Spanish

Sycamore Junior High School, 1801 E. Sycamore St., Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

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 recognitions on social media.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



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 to attend (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; includes exhibitor table at the event.
- At least one staff member to attend (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; includes 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 to attend (in person)
- Health/Resource Fair, open to the public



October 3, 10 a.m.–2 p.m., 20 Years Anniversary Celebration & 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 to attend (in person)
- Health/Resource Fair, open to the public



October 7 thru 8, 8 a.m.–5 p.m., 2026 Future of Healthcare Conference, hosted by Advance OC

University of California Irvine, 5270 California Ave. #100, Irvine

- Sponsorship fee: \$5,000; includes logo featured on all event promotional materials, speaking opportunity, and 10 tickets with reserved seating for one day.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



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; includes marketing, resource table.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



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; includes speaking opportunity at the welcoming and lunch session, resource table, acknowledgment on all marketing (website, social media, TV Talk Shows, community outreach and engagement events), large logo on event banner, five VIP conference tickets.
- At least one staff member to attend (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 Av., Ste. 203, Newport Beach

- At least one staff member to attend (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; includes resource booth.
- At least one staff member to attend (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; includes a resource booth.
- At least one staff member to attend (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; includes a resource table, presentation, and marketing.
- At least one staff member to attend (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 to attend (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



October 15, 10 a.m.–2 p.m., Annual Senior Resource Fair, hosted by the City of Laguna Niguel

Sea Country Senior and Community Center, 24602 Aliso Creek Rd., Laguna Niguel

- At least one staff member to attend (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 to attend (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 to attend (in person)
- Health/Resource Fair, open to the public



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 to attend (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 to attend (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 to attend (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; includes recognition on AAF's website, from the event stage, in e-newsletter, on the banner displayed at the event.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



October 26, 9–11 a.m., CalOptima Health Medi-Cal Overview in Spanish

Anaheim High School, Virtual

- At least one staff member to present
- Community-based organization presentation, open to members/community



October 27, 9–10:30 a.m., CalOptima Health Community Connections Meeting, hosted by CalOptima Health

CalOptima Health, Virtual

- At least four staff members to attend
- Steering committee meeting, open to collaborative members

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
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

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

Contact

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

Recommended Action

Accept, receive, and file the Fiscal Year 2025-26 CalOptima Health consolidated audited financial statements as submitted by independent auditors, Baker Tilly US, LLP.

Background

At the May 28, 2026, meeting of the CalOptima Health Finance and Audit Committee, Baker Tilly US, LLP (Baker Tilly) presented the 2026 Financial Audit Planning. The audit plan included performing the mandatory annual consolidated financial statement audit and a review of relevant internal controls and compliance for CalOptima Health's major programs.

Discussion

Baker Tilly conducted the interim audit beginning May 26, 2026, and the year-end audit in July and August 2026. The significant audit areas that Baker Tilly reviewed included:

- Medical claims liability and claims expense;
- Capitation revenue and receivables; and
- Amounts due to the State of California or the California Department of Health Care Services.

Baker Tilly auditors conducted the audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) and the Government Auditing Standards.

During Fiscal Year (FY) 2025-26, CalOptima Health adopted and implemented (i) Governmental Accounting Standards Board (GASB) Statement No. 103 – *Financial Reporting Model Improvements*, to enhance the effectiveness of CalOptima Health's financial reports in providing information that is essential for decision making, and (ii) GASB Statement No. 104 – *Disclosure of Certain Capital Assets*, to improve transparency about capital assets in the financial statement notes. The implementation of these statements resulted in updates to the presentation and related disclosures of the financial statements.

The results of CalOptima Health's FY 2025-26 audit were positive. Specifically, the auditor:

- Proposed no changes in CalOptima Health's approach to applying critical accounting policies;
- Reported no significant difficulties during the audit; and
- Identified no uncorrected or material misstatements, material weaknesses, or significant control deficiencies.

As such, management recommends that the Board of Directors accept, receive, and file the CalOptima Health FY 2025-26 consolidated audited financial statements, as presented.

Fiscal Impact

There is no fiscal impact.

Concurrence

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

Attachments

1. [FY 2025-26 CalOptima Health Audited Financial Statements](#)
2. [Presentation by Baker Tilly US, LLP](#)

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Report of Independent Auditors and Financial Statements with
Supplementary Information

**Orange County Health Authority, A Public Agency dba
Orange Prevention and Treatment Integrated Medical
Assistance dba CalOptima Health**

June 30, 2026 and 2025



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Management's Discussion and Analysis

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

The purpose of management's discussion and analysis is to provide an objective and easily readable analysis of CalOptima Health's financial activities for the fiscal years ended June 30, 2026, and 2025, with emphasis on fiscal year 2026. Readers should review this discussion in conjunction with CalOptima Health's financial statements and accompanying notes to enhance their understanding of CalOptima Health's financial performance.

Overview of the Financial Statements

CalOptima Health's basic financial statements consist of the statements of net position, the statements of revenues, expenses, and changes in net position, the statements of cash flows, and the accompanying notes. The statements are prepared using the economic resources measurement focus and the accrual basis of accounting.

The statements of net position report all assets, deferred outflows of resources, liabilities, and deferred inflows of resources at fiscal year-end. The difference between those elements is reported as net position, including net investment in capital assets, restricted net position, and unrestricted net position.

The statements of revenues, expenses, and changes in net position report the current-year operating and nonoperating activities that increased or decreased net position. They connect the beginning and ending balances reported in the statements of net position.

The statement of cash flows reports cash receipts and payments by operating, noncapital financing, capital and related financing, and investing activities. They differ from the statements of revenues, expenses, and changes in net position because the latter include noncash items such as depreciation and amortization and recognize revenues and expenses when earned or incurred rather than when cash is received or paid.

In June 2025, CalOptima Health filed to expand the scope of the Knox-Keene Act License to participate in the State's Health Insurance Marketplace, Covered California. CalOptima Health is preparing to launch a Covered California line of business effective January 1, 2027.

Beginning January 1, 2026, changes in California Medi-Cal initiatives to full-scope Medi-Cal coverage for undocumented adults included a freeze on enrollment for adults ages 19 and older and the reinstatement of asset tests during renewals. This resulted in a decrease in enrollment beginning January 1, 2026.

CalOptima Health reports its activities in a single enterprise fund. The financial statements include the accounts and transactions associated with Medi-Cal, OneCare, the Program of All-Inclusive Care for the Elderly (PACE), the Multipurpose Senior Services Program, remaining OneCare Connect activity, and Covered California start-up activity. Because the enterprise fund encompasses CalOptima Health's primary government activities, the analysis in this management's discussion and analysis also serves as the analysis of its major fund.

Financial Summary

CalOptima Health's net position increased by \$314.5 million, or 11.2 percent during fiscal year 2026. At June 30, 2026, assets and deferred outflows of resources exceeded liabilities and deferred inflows of resources by \$3.115 billion.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Management's Discussion and Analysis**

Key Operating Indicators

The table below compares key operating indicators for CalOptima Health for the fiscal years ended June 30, 2026 and 2025:

Key Operating Indicators	2026	2025	2024
Members (at end of fiscal period)			
Medi-Cal program	787,436	886,034	901,303
OneCare	18,958	17,664	17,253
PACE	577	515	496
Average member months			
Medi-Cal program	839,954	892,630	932,770
OneCare	18,440	17,280	17,488
PACE	547	506	457
Operating revenues (in millions)	\$ 5,157	\$ 5,033	\$ 5,372
Operating expenses (in millions)			
Medical expenses	4,708	4,621	4,403
Administrative expenses	265	260	230
Operating income (in millions)	<u>\$ 185</u>	<u>\$ 151</u>	<u>\$ 739</u>
Operating revenues PMPM (per member per month)	\$ 500	\$ 441	\$ 471
Operating expenses PMPM			
Medical expenses PMPM	457	405	395
Administrative expenses PMPM	26	23	20
Operating income PMPM	<u>\$ 17</u>	<u>\$ 13</u>	<u>\$ 56</u>
Medical loss ratio	91.3%	91.8%	82.0%
Administrative expenses ratio	5.1%	5.2%	4.3%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	\$ 753	\$ 870	\$ 658
Administrative expenses (in millions)	\$ 753	\$ 864	\$ 658

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Management's Discussion and Analysis**

Condensed Financial Position

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

Financial Position	2026	2025	2024	Change from 2025 to 2026	
				Amount	Percentage
ASSETS					
Current assets	\$ 2,870,184	\$ 2,576,425	\$ 2,871,751	\$ 293,759	11.4%
Board-designated assets and restricted cash	1,778,855	1,717,108	1,138,063	61,747	3.6%
Net pension asset	4,069	-	-	4,069	100.0%
Capital assets, net	85,561	79,772	77,270	5,789	7.3%
Subscription assets, net	24,709	18,851	19,291	5,858	31.1%
Total assets	4,763,378	4,392,156	4,106,375	371,222	8.5%
DEFERRED OUTFLOWS OF RESOURCES	30,923	28,626	75,899	2,297	8.0%
Total assets and deferred outflows of resources	\$ 4,794,301	\$ 4,420,782	\$ 4,182,274	\$ 373,519	8.4%
LIABILITIES					
Current liabilities	\$ 1,566,388	\$ 1,493,285	\$ 1,547,922	\$ 73,103	4.9%
Other liabilities	82,910	111,434	170,028	(28,524)	-25.6%
Subscription liability, net of current portion	13,148	11,170	10,596	1,978	17.7%
Total liabilities	1,662,446	1,615,889	1,728,546	46,557	2.9%
DEFERRED INFLOWS OF RESOURCES	16,723	4,310	8,646	12,413	288.0%
NET POSITION					
Net investment in capital assets	87,072	80,810	78,830	6,262	7.7%
Restricted by legislative authority	134,333	129,342	127,853	4,991	3.9%
Unrestricted	2,893,727	2,590,431	2,238,399	303,296	11.7%
Total net position	3,115,132	2,800,583	2,445,082	314,549	11.2%
Total liabilities, deferred inflows of resources, and net position	\$ 4,794,301	\$ 4,420,782	\$ 4,182,274	\$ 373,519	8.4%

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

Condensed Changes in Net Position

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

Results of Operations	2026	2025	2024	Change from 2025 to 2026	
				Amount	Percentage
PREMIUM REVENUES	\$ 5,157,351	\$ 5,033,535	\$ 5,372,964	\$ 123,816	2.5%
Total operating revenues	5,157,351	5,033,535	5,372,964	123,816	2.5%
MEDICAL EXPENSES	4,708,130	4,621,433	4,403,235	86,697	1.9%
ADMINISTRATIVE EXPENSES	264,564	259,859	229,511	4,705	1.8%
Total operating expenses	4,972,694	4,881,292	4,632,746	91,402	1.9%
OPERATING INCOME	184,657	152,243	740,218	32,414	21.3%
NON-OPERATING REVENUES AND EXPENSES	129,891	203,258	34,858	(73,367)	-36.1%
Increase in net position	314,548	355,501	775,076	(40,953)	-11.5%
NET POSITION, beginning of year	2,800,583	2,445,082	1,670,006	355,501	14.5%
NET POSITION, end of year	\$ 3,115,131	\$ 2,800,583	\$ 2,445,082	\$ 314,548	11.2%

Detailed Analyses

Medi-Cal remained the primary source of CalOptima Health's activity, accounting for 90.4 percent and 90.9 percent, of its annual revenues during fiscal years 2026 and 2025, respectively. OneCare accounted for 8.4 percent and 8.1 percent of its annual revenues during fiscal years 2026 and 2025, respectively. PACE accounted for 1.2 percent and 1.1 percent of its annual revenues during fiscal years 2026 and 2025, respectively.

Financial Position

Current assets increased \$293.8 million, from \$2.576 billion at June 30, 2025, to \$2.870 billion at June 30, 2026. The increase was primarily attributable to a \$519.2 million increase in short-term Investments with a decrease of \$110.2 million in cash and cash equivalents. The growth is largely due to interest earned on investments and net purchases over the year, supported by capital inflows into the operating account. Managed Care Organization (MCO) tax receivable from the Department of Health Care Services (DHCS) decreased \$129.3 million due to the timing of payments.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

Current liabilities increased \$73.1 million, primarily because of an increase of \$141.2 million in amounts due to DHCS for the Adult and Adult Expansion Unsatisfactory Immigration Status (UIS) and Enhanced Care Management Risk Corridor established by DHCS. Fiscal year 2026 included an additional accrual of \$46.6 million for the Calendar Year (CY) 2024 UIS Risk Corridor due to differences in logic used by DHCS. The CY 2024 UIS Risk Corridor was paid in July 2026. The increase in Current liabilities was offset by a decrease of \$67.7 million in medical claims and capitation liabilities driven primarily by the lower enrollment. Long-term liabilities decreased \$27.8 million, principally because the estimated Community Reinvestment and Quality Achievement obligation decreased approximately \$21.2 million, and the net pension liability decreased approximately \$5.8 million. Deferred inflows of resources increased \$12.4 million, primarily from pension-related changes.

Unrestricted net position increased \$303.3 million to \$2.894 billion, primarily because current-year revenues exceeded expenses. Restricted net position increased \$5.0 million to \$134.3 million. The restricted amount is limited by legislative authority, while Board-designated assets remain within unrestricted net position and may be redesignated by the Board. Those designations reduce resources available for other future uses unless the Board revises its policy.

In April 2025, the Board revised the desired Tier One reserve range from 2.5 to 3.0 months of consolidated capitation revenue to 2.5 to 4.0 months. As of June 30, 2026, Tier One investment portfolios equaled 3.77 times the average monthly consolidated capitation revenue. Tier Two investment portfolios are statutorily designated reserves intended to satisfy Tangible Net Equity (TNE) requirements; the desired level is 100 percent to 110 percent of the requirement. CalOptima Health's total reserve level was 105 percent of the minimum required TNE as of June 30, 2026, compared with 102 percent as of June 30, 2025. CalOptima Health also maintained the \$300,000 restricted deposit required under the Knox-Keene Health Care Service Plan Act of 1975.

Results of Operations

The increase in net position was \$314.5 million in fiscal year 2026, \$41.0 million less than the \$355.5 million increase in fiscal year 2025. Operating income increased \$32.4 million, while non-operating revenues and expenses decreased \$73.4 million.

Operating Revenues

Operating revenues increased \$123.8 million, or 2.5 percent, to \$5.157 billion. The increase is driven primarily by a 6.4% increase in premium capitation rates from CY 2025 and an increase in Hospital Directed Payments of \$120.0 million. This increase is offset by an average decrease in membership of 5.9% due to the impacts of policy changes mandated by federal H.R. 1, "One Big Beautiful Bill Act" signed on July 4, 2025.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

Medical Expenses

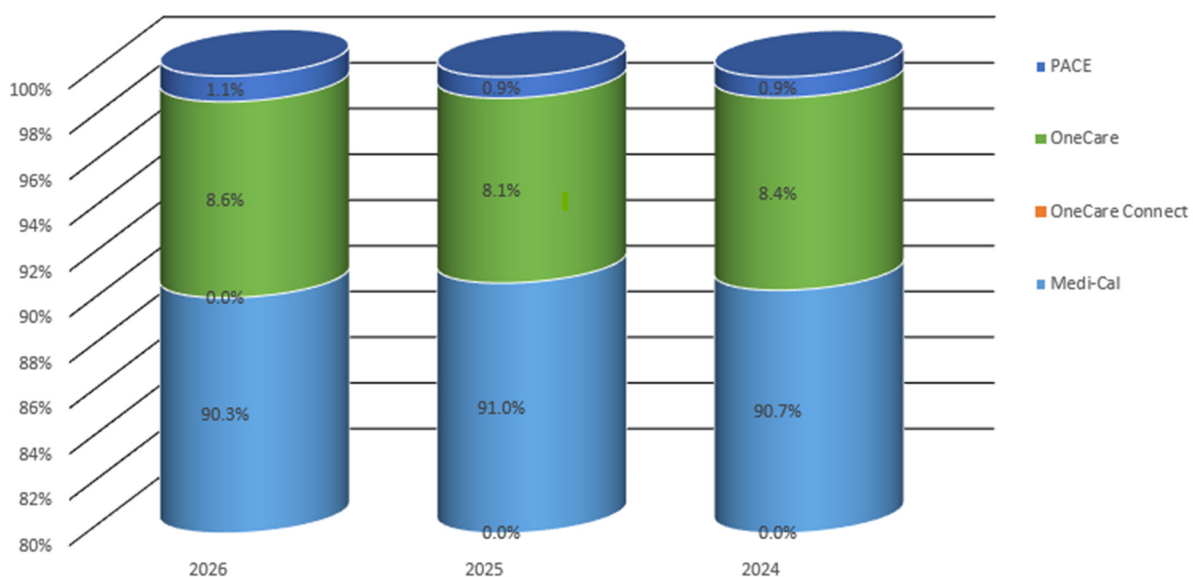
Medical expenses increased \$86.7 million, or 1.9 percent, to \$4.708 billion. Medi-Cal increased \$45.8 million, from \$4.206 billion in fiscal year 2025 to \$4.252 billion in fiscal year 2026. Medi-Cal Provider capitation expense decreased \$44.8 million, or 3.3 percent due to decrease in membership. Medi-Cal Provider capitation expense was \$1.326 billion in fiscal year 2026 compared with \$1.371 billion in fiscal year 2025. Capitated member enrollment averaged 572,602 in fiscal year 2026, or 66.7 percent of enrollment, compared with 612,173, or 67.3 percent, in fiscal year 2025. Medi-Cal Claims expense to providers and facilities, including long-term care services (LTC), increased 1.6 percent due to provider rate increases and higher utilization and higher member acuity of the remaining population. Other medical expenses increased by \$56.2 million due to an increase in Hospital Directed Payments by \$131.6 million offset by a decrease in Incentive payments of \$72.2 million. The decrease is due to lower estimated incentive payments for fiscal year 2026 and a \$24.7 million release of fiscal year 2025 accruals.

OneCare increased by \$31.1 million from \$372.3 million in fiscal year 2025 to \$403.4 million in fiscal year 2026 and PACE increased by \$9.7 million from \$43.4 million in fiscal year 2025 to \$53.1 million in fiscal year 2026. The increases are driven primarily by increased enrollment, higher claims utilization, and enhanced supplemental benefits.

In addition to the items mentioned above, total Hospital Quality Assurance Fee (HQAF) payments received and passed through to hospitals decreased by \$106.6 million. No HQAF payments were received and paid in fiscal year 2026 due to delays at the federal and state level.

Below are comparison charts of total medical expenses by line of business and their respective percentages of the overall medical expenditures by fiscal year (Chart 1) and medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year (Chart 2).

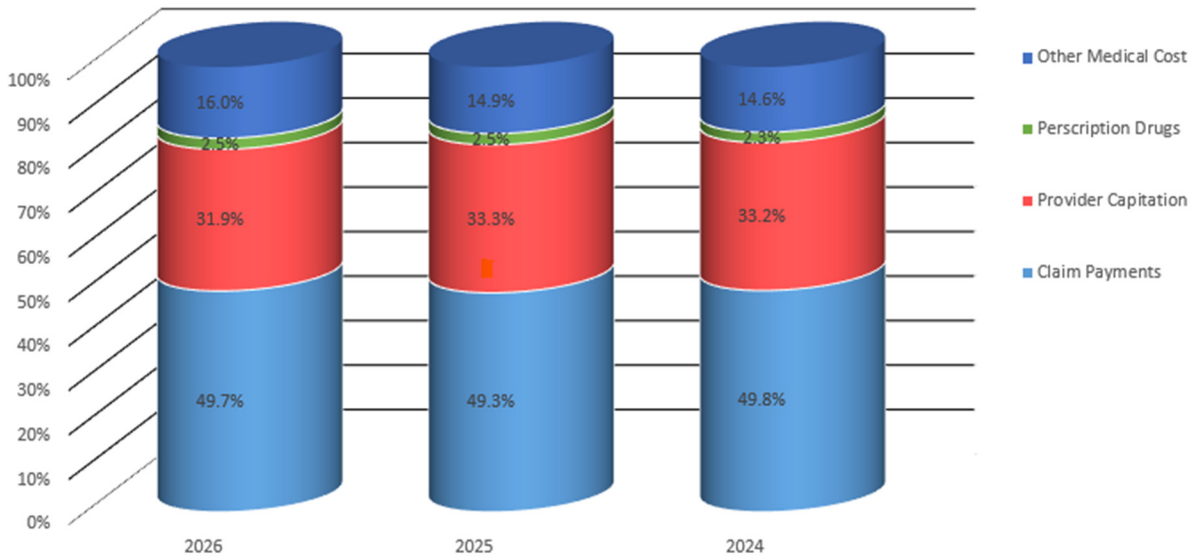
Chart 1: Medical Expenses by Line of Business



Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

Chart 2: Consolidated Medical Expenses by Major Category



Administrative Expenses

Administrative expenses increased \$4.7 million, or 1.8 percent, to \$264.6 million. The increase was driven primarily by \$3.4 million in higher supplies, occupancy, and other costs, \$3.0 million in higher salaries and benefits, \$2.0 million in additional depreciation and amortization, and \$1.4 million in higher professional fees, all offset by \$5.1 million in lower purchased services. Administrative expenses were 5.1 percent of operating revenues in fiscal year 2026 compared with 5.2 percent in fiscal year 2025.

Nonoperating Revenues and Expenses

Net non-operating income decreased \$73.4 million, from \$203.3 million in fiscal year 2025 to \$129.9 million in fiscal year 2026. The decrease is driven primarily by \$55.8 million in lower net investment income and \$13.9 million increase in grant expense.

Enrollment and Other Operating Factors

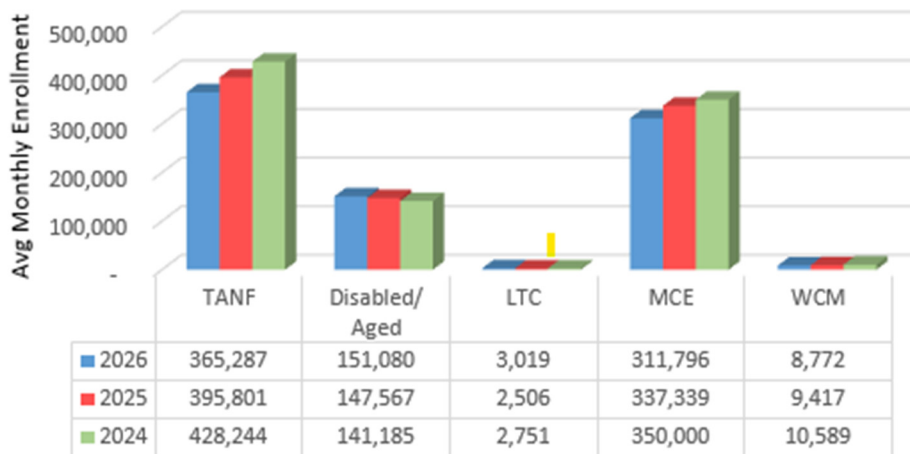
During fiscal year 2026, CalOptima Health served an average Medi-Cal enrollment of 839,954 members, a decrease of 52,676 members, or 5.9 percent, from 892,630 members in fiscal year 2025. The decrease was primarily attributable to federal and state policy changes that froze enrollment for members 19 years or older with UIS and asset test reinstatement effective January 1, 2026. The Medi-Cal decrease contributed to lower premium revenue, while rate increases, directed payments, and utilization affected per-member revenue and expense trends.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during fiscal year 2026 and fiscal year 2025.

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



Significant aid categories are defined as follows:

Temporary Assistance to Needy Families (TANF) includes families, children, and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from the CalOptima Health, Health Net, and Kaiser Healthy Family programs.

Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals aged 65 and older who receive supplemental security income (SSI) checks, are medically needy, or have an income of 100 percent or less of the federal poverty level.

LTC includes frail elderly adults, nonelderly adults with disabilities, and children with developmental disabilities and other disabling conditions that require LTC services.

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

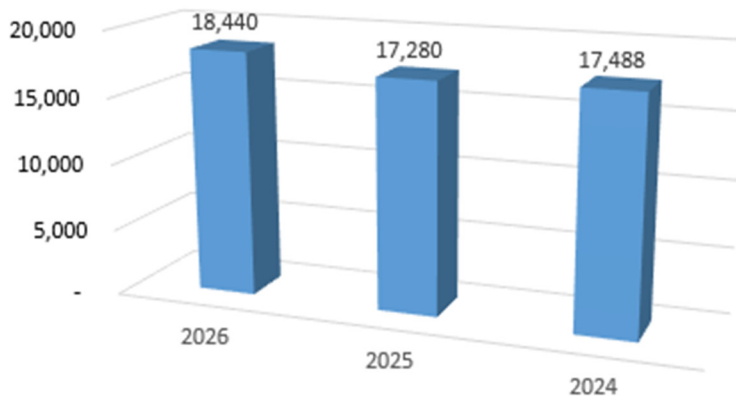
CalOptima Health's Whole Child Model (WCM) program includes children who are California Children's Services (CCS) eligible. These members are receiving their CCS services and non-CCS services under the WCM program.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

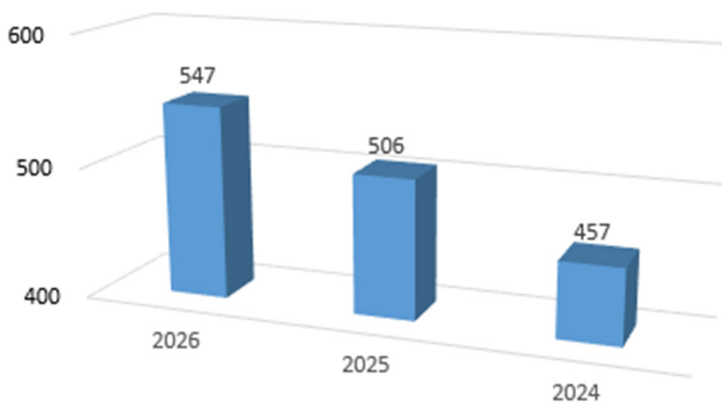
OneCare was introduced in October 2005 as a Medicare Advantage Special Needs Plan. It provides a full range of health care services to members who are eligible for both the Medicare and Medi-Cal programs (i.e., dual eligible). The average member months increased by 1,161 members from 17,280 in fiscal year 2025 to 18,440 in fiscal year 2026. The chart below displays the average member months for the past two years.

Chart 4: OneCare Membership by Fiscal Year
(Shown as Average Member Months)



PACE began operations in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them to continue living independently in the community. The average member months were 547 and 506 for the fiscal years ended June 30, 2026 and 2025, respectively. The chart below displays the average member months for the past two years.

Chart 5: PACE Membership by Fiscal Year
(Shown as Average Member Months)



Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

Significant Capital Asset and Long-Term Financing Activity

Net capital assets increased \$5.8 million to \$85.6 million at June 30, 2026. Capital-asset purchases and additions were \$32.1 million, including \$15.3 million of construction-in-progress, \$8.0 million of computers and software, including \$4.4 million for a customer relationship management system and \$1.5 million for a new financial system, and \$7.2 million of building additions, of which \$5.4 million was for the Street Medicine Traffic Control Office. During the year, \$16.7 million was transferred from construction in progress to completed assets. There were no gross retirements during the year. CalOptima Health is in the process of purchasing a second PACE Center building.

CalOptima Health acquired \$17.3 million of subscription-based information technology arrangement assets through noncash transactions and paid \$13.5 million on subscription obligations. At June 30, 2026, the net right-to-use subscription asset was \$24.7 million, with the related liability at \$22.0 million. The arrangements extend through fiscal year 2030. Future payments under noncancelable subscription-based information technology arrangements totaled approximately \$26.5 million at June 30, 2026. During the fiscal year ended June 30, 2026, CalOptima Health retired \$7.0 million of subscription assets and the related accumulated amortization.

CalOptima Health had no separately reported bonded debt or public-private or public-public partnership liabilities at June 30, 2026. Accordingly, changes in credit ratings and legal debt limitations were not applicable. The most significant long-term financing activity was the subscription liability described above.

Currently Known Facts, Decisions, or Conditions

Covered California

On July 21, 2026, Covered California announced CalOptima Health's entrance into the marketplace beginning January 1, 2027. Management has forecasted the start-up and budgetary impacts of the new product, will assess any additional administrative and implementation activities before and after launch, and will monitor the financial effects.

State Fiscal Year 2026-27 Budget and Medi-Cal Actions

The State fiscal year 2026-27 budget was signed on June 26, 2026. The following enacted or funded Medi-Cal actions are expected to affect future enrollment, benefits, capitation revenue, provider reimbursement, or medical expense:

- Transition of undocumented individuals from Medi-Cal managed care to Medi-Cal fee-for-service effective January 1, 2027;
- Implementation of the provisions in federal law that will impact Medi-Cal expansion members beginning January 1, 2027, including work requirements and eligibility redeterminations at least every six months; and
- Refinement of eligibility criteria and utilization management for CalAIM enhanced care management and community support.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

Medicaid Provider Tax

The budget seeks to establish an alternative, federally compliant Medicaid Provider Tax to take effect January 1, 2027. Management will assess the full effect of the revised tax and anticipates budgetary and operational adjustments. The discontinuation could affect future capitation revenue, provider funding, and the resources available for CalOptima Health programs.

Federal and State Audits

DHCS Routine Annual Audit (2025) – In October 2024, DHCS formally engaged CalOptima Health for its annual medical program audit. The audit covered the provision of Medi-Cal services for the period of February 1, 2024, through January 31, 2025, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations. In May 2025, CalOptima Health received its audit findings report and request for corrective action. The audit report identified four findings that required corrective action. CalOptima Health received confirmation of the acceptance of the Corrective Action Plan (CAP) and audit closure in November 2025. This audit is considered closed with no further action required.

DHCS Routine Annual Audit (2026) – On November 12, 2025, DHCS formally engaged CalOptima Health for its annual routine medical program audit. The audit covered the provision of Medi-Cal services for the period of January 1, 2025, through December 31, 2025, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations. In July 2026, CalOptima Health received its audit findings report and request for corrective action. The audit report identified four findings that required corrective action. As of this writing, CalOptima Health has submitted all required deliverables and awaits DHCS assessment.

DHCS State Supported Services (SSS) Audit (2026) – At the time of engagement for its annual routine audit in November 2025, DHCS simultaneously engaged CalOptima Health in an SSS audit related to abortion services. DHCS conducted this audit in conjunction with the DHCS routine annual audit for the period of January 1, 2025, through December 31, 2025, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations related to SSS. In July 2026, CalOptima Health received its audit findings report, which confirmed no findings for SSS. This audit is considered closed with no further action required.

DHCS PACE Audit – In February 2026, DHCS formally engaged CalOptima Health for its routine review of CalOptima Health's PACE Organization. The audit covered the provision of PACE services from January 1, 2025, through February 1, 2026. CalOptima Health is currently awaiting the final findings report and formal request for corrective action from DHCS.

Payment Year (PY) 2019 Risk Adjustment Data Validation (RADV) Audit – On June 12, 2025, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima Health that its OneCare (H5433) plan was selected for the PY 2019 RADV Audit. CMS will be conducting medical record reviews for a sample of OneCare enrollees to validate the accuracy of a subset of PY 2019 risk adjustment data and payments associated with encounters with dates of service from January 1, 2018, through December 31, 2018. CalOptima Health submitted medical records to CMS to validate risk adjustment data. CalOptima Health is currently awaiting audit results from CMS.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Management's Discussion and Analysis**

CMS 1/3 Financial Audit – On September 24, 2025, CMS notified CalOptima Health that its PACE plan (H7501) was selected for the CY 2024 CMS 1/3 Financial Audit. CMS's contractor, acting in the capacity of CMS agents, conducted the audit by requesting records and supporting documentation for, but not limited to, claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related party transactions, general administrative expenses and Direct and Indirect Remuneration (DIR). On June 8, 2026, CMS issued the final audit report. The audit report identified one observation and no findings. Nothing further was required, as CMS did not require a CAP.

PY 2020 RADV Audit – On March 30, 2026, CMS notified CalOptima Health that its OneCare (H5433) plan was selected for the PY 2020 RADV Audit. CMS will be conducting medical record reviews for a sample of OneCare enrollees 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. CalOptima Health submitted medical records to CMS to validate risk adjustment data. CalOptima Health is currently awaiting audit results from CMS.

PY 2021 RADV Audit – On May 29, 2026, CMS notified CalOptima Health that its OneCare (H5433) plan was selected for the PY 2021 RADV Audit. CMS will be conducting medical record reviews for a sample of OneCare enrollees to validate the accuracy of a subset of PY 2021 risk adjustment data and payments associated with encounters with dates of service from January 1, 2020, through December 31, 2020. CalOptima Health is required to submit medical records to validate risk adjustment data. The medical record submission window opened on June 22, 2026, and will close on November 6, 2026.

Requests for Information – This financial report has been prepared to provide readers with an overview of CalOptima Health's operations. Questions or requests for additional information should be directed to CalOptima Health, 505 City Parkway West, Orange, California 92868, or by telephone at (714) 347-3237.

Report of Independent Auditors

The Board of Directors

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health (the "Organization"), which comprise the statements of net position as of June 30, 2026 and 2025, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Organization as of June 30, 2026 and 2025, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Organization and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedule of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of changes in total OPEB liability and related ratios, as listed in the table of contents, be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the GASB who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Irvine, California
October 1, 2026

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upon for any purpose

Financial Statements

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Statements of Net Position
June 30, 2026 and 2025**

	2026	2025
CURRENT ASSETS		
Cash and cash equivalents	\$ 365,036,439	\$ 475,203,956
Investments	1,860,077,839	1,340,926,602
Premiums due from the State of California and CMS	612,910,005	727,250,234
Prepaid expenses and other	32,159,874	33,044,564
Total current assets	2,870,184,157	2,576,425,356
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	5,291,865	6,677,329
Investments	1,772,717,051	1,710,130,179
Restricted collateral	546,000	-
Restricted deposit	300,000	300,000
Total board-designated assets and restricted cash	1,778,854,916	1,717,107,508
NET PENSION ASSET	4,069,081	-
CAPITAL ASSETS, NET	85,561,039	79,772,146
SUBSCRIPTION ASSETS, NET	24,709,360	18,850,560
Total assets	4,763,378,553	4,392,155,570
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	29,926,013	27,437,072
Other postemployment benefit	997,000	1,189,000
Total deferred outflows of resources	30,923,013	28,626,072
Total assets and deferred outflows of resources	\$ 4,794,301,566	\$ 4,420,781,642

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Statements of Net Position
June 30, 2026 and 2025**

	2026	2025
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	\$ 343,692,218	\$ 382,673,339
Provider capitation and withholds	125,273,073	153,993,364
Accrued reinsurance costs to providers	18,790,175	15,792,031
Due to the State of California and CMS	1,006,232,557	865,014,787
Unearned revenue	5,921,439	7,764,476
	1,499,909,462	1,425,237,997
Subscription liability	10,050,582	6,641,757
Accounts payable and other	23,269,803	31,558,870
Accrued payroll and employee benefits and other	33,159,179	29,845,787
	1,566,389,026	1,493,284,411
COMMUNITY REINVESTMENT	66,941,338	88,098,111
POSTEMPLOYMENT HEALTH CARE PLAN	15,772,000	17,249,000
SUBSCRIPTION LIABILITY, net of current portion	13,147,809	11,170,484
NET PENSION LIABILITY	-	5,840,992
OTHER LONG-TERM LIABILITIES	196,705	245,394
	1,662,446,878	1,615,888,392
DEFERRED INFLOWS OF RESOURCES		
Net pension	14,364,193	1,321,519
Other postemployment benefit	2,359,000	2,988,000
	16,723,193	4,309,519
NET POSITION		
Net investment in capital assets	87,072,008	80,810,465
Restricted by legislative authority	134,332,567	129,341,855
Unrestricted	2,893,726,920	2,590,431,411
	3,115,131,495	2,800,583,731
	\$ 4,794,301,566	\$ 4,420,781,642

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health**

**Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2026 and 2025**

	2026	2025
REVENUES		
Premium revenues	\$ 5,157,350,554	\$ 5,033,535,326
Total operating revenues	5,157,350,554	5,033,535,326
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	2,216,220,086	2,181,804,161
Provider capitation	1,326,073,718	1,370,782,575
Other medical	709,346,123	653,207,203
PACE	53,073,074	43,370,651
OneCare	403,416,798	372,267,309
Total medical expenses	4,708,129,799	4,621,431,899
Administrative expenses		
Salaries, wages, and employee benefits	158,032,410	155,054,752
Supplies, occupancy, insurance, and other	50,070,724	46,631,923
Purchased services	24,213,005	29,268,757
Depreciation and amortization	11,592,305	9,606,171
Professional fees	20,655,957	19,297,822
Total administrative expenses	264,564,401	259,859,425
Total operating expenses	4,972,694,200	4,881,291,324
OPERATING INCOME	184,656,354	152,244,002
NON-OPERATING REVENUES (EXPENSES)		
Net investment income	138,502,614	194,295,685
Grant expense	(23,568,780)	(9,627,088)
Community reinvestment	21,156,773	18,578,540
Other (expense) income, net	(6,199,197)	10,386
Total non-operating revenues	129,891,410	203,257,523
Change in net position	314,547,764	355,501,525
NET POSITION, beginning of year	2,800,583,731	2,445,082,206
NET POSITION, end of year	\$ 3,115,131,495	\$ 2,800,583,731

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Statements of Cash Flows
Years Ended June 30, 2026 and 2025**

	2026	2025
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	\$ 5,411,065,516	\$ 4,787,297,339
Payments to providers and facilities	(4,772,881,756)	(4,622,047,560)
Payments to vendors	(90,934,005)	(91,530,982)
Payments to employees	(155,989,358)	(148,420,991)
Net cash provided by (used in) operating activities	391,260,397	(74,702,194)
CASH FLOWS USED IN CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments on subscription lease obligations	(13,826,266)	(9,431,517)
Purchases of capital assets	(15,320,041)	(11,265,905)
Net cash used in capital and related financing activities	(29,146,307)	(20,697,422)
CASH FLOWS USED IN NON-CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments of grants to providers	(23,568,780)	(8,959,554)
Net cash used in non-capital and related financing activities	(23,568,780)	(8,959,554)
CASH FLOWS USED IN INVESTING ACTIVITIES		
Investment income received	178,602,330	202,322,612
Purchases of securities	(17,864,845,967)	(23,493,651,011)
Sales of securities	17,243,847,606	23,343,549,354
Other nonoperating cash payments	(5,682,278)	(667,534)
Payments related to rental activities	(634,518)	10,386
Net cash (used in) provided by investing activities	(448,712,827)	51,563,807
Net change in cash and cash equivalents	(110,167,517)	(52,795,363)
CASH AND CASH EQUIVALENTS, beginning of year	475,203,956	527,999,319
CASH AND CASH EQUIVALENTS, end of year	\$ 365,036,439	\$ 475,203,956
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	\$ 184,656,354	\$ 152,244,002
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation and amortization	20,947,579	17,742,390
Changes in assets and liabilities		
Premiums due from the State of California and CMS	114,340,229	(175,101,532)
Prepaid expenses and other	884,690	(19,337,664)
Medical claims liability	(38,981,121)	13,098,775
Provider capitation and withholds	(28,720,291)	(22,240,330)
Accrued reinsurance costs to providers	2,998,144	8,280,500
Due to the State of California and CMS	141,217,770	(72,264,390)
Unearned revenue	(1,843,037)	1,127,935
Accounts payable and other	(6,234,283)	14,868,965
Long term liabilities	(48,689)	245,394
Accrued payroll and employee benefits and other	3,313,392	3,959,119
Postemployment health care plan	(1,914,000)	(3,370,000)
Net pension liability	643,660	6,044,642
Net cash provided by (used in) operating activities	\$ 391,260,397	\$ (74,702,194)

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Statements of Cash Flows
Years Ended June 30, 2026 and 2025**

NONCASH CAPITAL FINANCING ACTIVITIES

Lease right-to-use assets acquired via lease obligations	<u>\$ 17,275,231</u>	<u>\$ 8,538,377</u>
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SUPPLEMENTAL SCHEDULE OF NONCASH OPERATING AND INVESTING ACTIVITIES

Change in net unrealized gain (loss) on investments	<u>\$ (13,625,095)</u>	<u>\$ 12,997,504</u>
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See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Notes to Financial Statements**

Note 1 – Organization

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health, is a County-Organized Health System (COHS) serving primarily Medi-Cal beneficiaries in Orange County, California. Effective August 4, 2022, Orange County Health Authority changed its dba name to CalOptima Health (CalOptima Health or the Organization). Pursuant to the California Welfare and Institutions Code, CalOptima Health was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance No. 3896 in August 1992. The Organization began operations in October 1995.

As a COHS, CalOptima Health maintains an exclusive contract with the State of California (the State) Department of Health Care Services (DHCS) to arrange for the provision of health care services to Orange County's Medi-Cal beneficiaries. Orange County had approximately 787,000 and 886,000 Medi-Cal beneficiaries for the years ended June 30, 2026 and 2025, respectively. CalOptima Health also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare & Medicaid Services (CMS). OneCare served approximately 19,000 and 17,700 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2026 and 2025, respectively.

CalOptima Health also contracts with the California Department of Aging to provide case management of social and health care services to approximately 500 Medi-Cal eligible seniors under the State's Multipurpose Senior Services Program (MSSP). Effective January 1, 2022, MSSP transitioned from a managed care plan benefit to a carved-out waiver benefit.

The Program of All-Inclusive Care for the Elderly (PACE) provides services to members 55 years of age or older who reside in the PACE service area and meet California nursing facility level-of-care requirements. The program receives Medicare and Medi-Cal funding and serves approximately 500 members.

CalOptima Health, in turn, subcontracts the delivery of health care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia and Shared Risk Groups. Additionally, CalOptima Health has direct contracts with hospitals and providers for its fee-for-service network.

CalOptima Health is Knox-Keene-licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox-Keene Health Care Service Plan Act of 1975 (the Act) to the extent incorporated by reference into CalOptima Health's contract with DHCS. As such, CalOptima Health is subject to the regulatory requirements of the Department of Managed Health Care (DMHC) under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of Tangible Net Equity (TNE), which CalOptima Health exceeded as of June 30, 2026 and 2025.

**Orange County Health Authority, A Public Agency dba Orange
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Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima Health is a COHS plan governed by a 10-member Board of Directors appointed by the Orange County Board of Supervisors. Effective for the year ended June 30, 2014, CalOptima Health began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors' role in appointing all members of the Board of Directors.

Basis of accounting – CalOptima Health uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of the financial statements in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows using current market rates applicable to the coupon rate, credit, and maturity of the investments.

Board-designated assets and restricted cash – Board-designated assets based on policy updates approved by the Board of Directors in April 2025 include amounts designated by the Board of Directors for the establishment of certain reserve funds for contingencies at a desired level between 2.5 and 4.0 months of consolidated capitation revenue (see Note 3). The Board of Directors also established a separate reserve to meet the statutory requirement for minimum TNE. Restricted cash represents a \$300,000 restricted deposit required by CalOptima Health as part of the Act (see Note 9).

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Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs, and minor replacements are charged to expense when incurred.

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life of lease, whichever is less

Fair value of financial instruments – The financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, premiums receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments, except for investments, generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima Health establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred-but-not-yet-reported (IBNR) claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima Health retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

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Provider capitation and withholds – CalOptima Health has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima Health withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima Health also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surpluses or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately \$10,997,000 and \$17,252,000 as of June 30, 2026 and 2025, respectively, and are included in provider capitation and withholds on the statements of net position. During the fiscal years ended June 30, 2026 and 2025, CalOptima Health incurred approximately \$1,324,514,000 and \$1,537,886,000, respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation and OneCare line items in the statements of revenues, expenses, and changes in net position. Estimated amounts due to health networks as of June 30, 2026 and 2025, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately \$125,273,000 and \$153,993,000, respectively.

Premium deficiency reserves – CalOptima Health performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is included in the calculation to estimate premium deficiency reserves. Management determined that no premium deficiency reserves were necessary as of June 30, 2026 and 2025.

Community reinvestment – Under its contract with DHCS, CalOptima Health is required to commit a percentage of net position toward investments into the community and an additional percentage if CalOptima Health does not meet specified quality measures established by the State, referred to as community reinvestment and quality achievement, respectively. As of June 30, 2025, in accordance with State contracts, the balance of the community reinvestment and quality achievement accrual was estimated at approximately \$38,166,000 and \$51,439,000, respectively. In July 2026, CalOptima Health received additional clarification from DHCS regarding the allocation of net investment income applicable to the reporting year to calculate the community reinvestment and quality achievement amounts. The clarification provided additional information regarding the calculation of obligations existing as of June 30, 2026, and accordingly, was considered in determining the related accruals as of June 30, 2026. As a result of the new information, there was a net decrease in liabilities related to community reinvestment for the year ended June 30, 2026, of approximately \$21,157,000. As of June 30, 2026, the balance of the community reinvestment and quality achievement accrual was estimated at approximately \$27,117,000 and \$39,824,000, respectively for a total estimated accrual of approximately \$66,941,000.

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Accrued compensated absences – Liabilities for compensated absences are recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability is recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, or (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. A liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—is not recognized until the leave commences. A liability for specific types of compensated absences is not recognized until the leave is used. CalOptima Health's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 23 days of paid time off (PTO) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. In the event that available PTO is not used by the end of the benefit year, employees may carry unused time off into subsequent years, up to the maximum accrual amount equal to two (2) times the employee's annual accrual. If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. Accumulated PTO will be paid to the employees upon separation from service with CalOptima Health. All compensated absences are included in accrued payroll and employee benefits and other on the statements of net position.

Net position – Net position is reported in three categories, defined as follows:

- *Net investment in capital assets* – This component of net position consists of capital assets, subscription-based information technology arrangements (SBITAs), and right of use (ROU) assets including restricted capital assets, net of accumulated depreciation and amortization, and is reduced by the outstanding balances of any bonds, notes, or other borrowings (if any) that are attributable to the acquisition, construction, or improvement of those assets.
- *Restricted by legislative authority* – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the laws or regulations of other governments. It also pertains to constraints imposed by law, constitutional provisions, or enabling legislation (see Note 9).
- *Unrestricted* – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets."

Operating revenues and expenses – CalOptima Health's statements of revenues, expenses, and changes in net position distinguish between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as non-operating revenues and expenses.

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Revenue recognition and due to or from the State and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State and for retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima Health in the amount of approximately \$423,993,000 and \$393,011,000 related to retroactive capitation rate adjustments based on receipt of new information from DHCS during the fiscal years ended June 30, 2026 and 2025, respectively.

These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by DHCS and validated by the State. The State provides CalOptima Health the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of premium revenue for the respective month.

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

	2026		2025	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	\$ 4,664,479,831	90.4%	\$ 4,575,205,978	90.9%
OneCare	432,026,077	8.4%	403,654,853	8.0%
PACE	60,844,646	1.2%	54,674,495	1.1%
	<u>\$ 5,157,350,554</u>	<u>100.0%</u>	<u>\$ 5,033,535,326</u>	<u>100.0%</u>
	2026		2025	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	\$ 509,601,310	83.1%	\$ 612,756,130	84.3%
OneCare	18,020,219	2.9%	46,717,321	6.4%
OneCare Connect	78,912,254	12.9%	62,370,135	8.6%
PACE	6,376,222	1.0%	5,406,648	0.7%
	<u>\$ 612,910,005</u>	<u>100.0%</u>	<u>\$ 727,250,234</u>	<u>100.0%</u>

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Intergovernmental transfer – CalOptima Health entered into an agreement with DHCS and Governmental Funding Entities to receive an intergovernmental transfer (IGT) through a capitation rate increase of approximately \$175,382,000 and \$160,474,000 during the fiscal years ended June 30, 2026 and 2025, respectively. Under the agreement, approximately \$173,335,000 and \$158,986,000 of the funds that were received from the IGT were passed through to Governmental Funding Entities and other contracted providers and organizations during the fiscal years ended June 30, 2026 and 2025, respectively. Under GASB, the amounts that will be passed through to Governmental Funding Entities are not reported in the statements of revenues, expenses, and changes in net position. CalOptima Health retains a portion of the IGT to support the administration of the program. Prior IGT funds retained by CalOptima Health from 2011 to 2017 must be used to enhance provider reimbursement rates, strengthen the delivery system, and support the administration of the IGT program. The funds expended must be tied to covered medical services provided to CalOptima Health's Medi-Cal beneficiaries. A retainer in the amount of approximately \$5,921,000 and \$4,505,000 as of June 30, 2026 and 2025, respectively, is included in unearned revenues in the statements of net position.

Directed Payments – DHCS implemented a hospital Directed Payment program with CalOptima Health. The program implements enhanced reimbursement to eligible and participating network hospitals for contracted services. This hospital Directed Payment program is broken into five types: (1) Private Hospital Directed Payment Program (PHDP), (2) Public Hospital Enhanced Payment Program (EPP), (3) Public Hospital Quality Incentive Program (QIP), (4) Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP), and (5) Equity and Practice Transformation (EPT). Under the Directed Payment program, approximately \$496,483,000 and \$383,270,000 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the fiscal years ended June 30, 2026 and 2025, respectively. The receipts from DHCS are included in premium revenues, and the payments made to the hospitals are included in other medical expenses in the statements of revenues, expenses, and changes in net position.

Medicare Part D – CalOptima Health covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima Health receives monthly from program premiums, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima Health recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima Health's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand-name prescription drugs in the coverage gap, represent payments for prescription drug costs for which CalOptima Health is not at risk.

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The risk corridor provisions compare costs targeted in CalOptima Health's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima Health or require CalOptima Health to refund to CMS a portion of the premiums CalOptima Health received. CalOptima Health estimates and recognizes an adjustment to premium revenue related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima Health records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying statements of net position based on the timing of the expected settlement. As of June 30, 2026 and 2025, the Part D payable balance was approximately \$2,778,000 and \$14,205,000, respectively, and is included in the due to the State of California and CMS line item on the accompanying statements of net position. As of June 30, 2026 and 2025, the Part D receivable balance was approximately \$56,117,000 and \$65,330,000, respectively, and is included in the premium due from the State and CMS line item on the accompanying statements of net position.

Income taxes – CalOptima Health operates under the purview of the Internal Revenue Code (IRC), Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima Health is not subject to federal or state taxes on related income. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Premium taxes – Effective July 1, 2016, Senate Bill X2-2 (SB X2-2), Managed Care Organization Tax, authorized DHCS to implement a Managed Care Organization (MCO) provider tax subject to approval by CMS. The tax is based on enrollment (total member months) within specified tiers that are assessed different tax rates. The MCO tax was subsequently extended through December 31, 2022.

Assembly Bill 119 (AB 119), as subsequently amended, authorized an MCO provider tax effective April 1, 2023 through December 31, 2026. The current MCO tax is assessed on applicable managed care organizations based on enrollment and is used to support the Medi-Cal program, including provider payment increases and other Medi-Cal expenditures. CMS approved the current MCO tax structure through December 31, 2026.

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During 2026, changes in federal requirements for health care-related taxes affected California's ability to continue the existing MCO tax structure beyond its current authorized term. The existing MCO tax remains in effect through December 31, 2026; however, the current tax structure will no longer be federally approvable after that date. DHCS has proposed a modified MCO tax structure effective January 1, 2027 that is intended to comply with the revised federal requirements. The proposed tax would apply to calendar years 2027 through 2029, subject to applicable conditions and federal approval. As the date the financial statements were available to be issued, federal approval of the proposed MCO tax structure had not been received.

Based on the current approved MCO tax structure, each MCO's total tax liabilities for the fiscal years ended June 30, 2026 and 2025, were calculated. CalOptima Health recognized premium tax expense of approximately \$753,195,000 and \$863,939,000 as a reduction of premium revenues in the statements of revenues, expenses, and changes in net position for the fiscal years ended June 30, 2026 and 2025, respectively. As of June 30, 2026 and 2025, CalOptima Health's MCO tax liability was approximately \$201,148,000 and \$201,453,000, respectively, and is included in the due to the State of California and CMS line item on the accompanying statements of net position.

Risk corridors – All risk corridors are subject to certain thresholds of medical expenses compared to premium revenues. Variances exceeding the thresholds may require CalOptima Health to refund premium revenues back to DHCS. CalOptima Health estimates and recognizes an adjustment to premium revenues based on actual membership and capitation rates in effect. As of June 30, 2026 and 2025, CalOptima Health recognized a liability of approximately \$344,334,000 and \$204,585,000, respectively, related to the risk corridors, which is included in the due to the State of California and CMS line item on the statements of net position. During the fiscal year ended June 30, 2026, the reduction to premium revenue was approximately \$139,750,000 and for the fiscal year ended June 30, 2025, the decrease of premium revenue was approximately \$47,635,000 related to the risk corridors, which is included in premium revenues on the statements of revenues, expenses, and changes in net position. Below is a list of programs with risk corridor accruals as of June 30, 2026 and 2025:

- Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)
- Coordinated Care Initiative (CCI)
- Bridge Period COVID-19
- Enhanced Care Management
- UIS

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions and pension expense, information about the fiduciary net position of CalOptima Health's Miscellaneous Plan of the Orange County Health Authority (the CalPERS Plan) and additions to or deductions from the Organization's fiduciary net position have been determined on the same basis as they are reported by California Public Employees Retirement Systems (CalPERS). For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

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Subscription-Based Information Technology Arrangements – CalOptima Health is the end user for various SBITAs. Short-term SBITAs, which have a maximum possible term of 12 months, are recognized as an outflow of resources when payment is made. For SBITAs with subscription terms extending beyond one year, CalOptima Health recognizes a right-to-use subscription asset and a corresponding subscription liability. Initial measurement of the subscription asset/liability is calculated at the present value of payments expected to be paid during the subscription term, discounted using the incremental borrowing rate. The right-to-use subscription asset is amortized on a straight-line basis over the subscription term.

Reclassifications – Certain reclassifications have been made to the prior-year amounts to conform to the current-year presentation.

Recent accounting pronouncements – In April 2024, GASB issued Statement No. 103, *Financial Reporting Model Improvements* (GASB 103). The objective of GASB 103 is to improve key components of the financial reporting model. The purposes of the improvements are to (a) enhance the effectiveness of the financial reporting model in providing information that is essential for decision making and assessing a government's accountability and (b) address certain application issues identified through pre-agenda research conducted by the GASB. GASB 103 is effective for CalOptima Health during the fiscal year ending June 30, 2026. CalOptima Health adopted GASB 103 during the fiscal year ending June 30, 2026. The adoption resulted in changes to certain financial statement presentation and disclosures but did not have a material impact on the amounts reported in the financial statements.

In September 2024, GASB issued Statement No. 104, *Disclosure of Certain Capital Assets* (GASB 104). The objective of GASB 104 is to provide users of government financial statements with essential information about certain types of capital assets. GASB 104 requires certain types of capital assets to be disclosed separately in the capital assets note disclosures required by GASB Statement No. 34 as well as certain intangible assets to be disclosed separately by major class. GASB 104 also requires additional disclosures for capital assets held for sale. This Statement requires that capital assets held for sale be evaluated each reporting period. GASB 104 is effective for CalOptima Health during the fiscal year ending June 30, 2026. CalOptima Health adopted GASB 104 during the fiscal year ending June 30, 2026. The adoption resulted in changes to the capital asset disclosures but did not have a material impact on the amounts reported in the financial statements.

In December 2025, GASB issued Statement No. 105, *Subsequent Events* (GASB 105). The objective of GASB 105 is to improve the financial reporting requirements for subsequent events, thereby enhancing consistency in their application and better meeting the information needs of financial statement users. GASB 105 defines subsequent events as transactions or other events that occur after the date of the financial statements but before the date the financial statements are available to be issued. GASB 105 also clarifies the subsequent events that constitute recognized and non-recognized events and establishes specific note disclosure requirements for non-recognized events. In addition, GASB 105 requires disclosure of the date through which subsequent events have been evaluated. GASB 105 is effective for CalOptima Health during the fiscal year ending June 30, 2027. CalOptima Health has not yet determined the impact, if any, that the adoption of GASB 105 will have on its financial statements.

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Note 3 – Cash, Cash Equivalents, and Investments

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

	2026	2025
Current assets		
Cash and cash equivalents	\$ 365,036,439	\$ 475,203,956
Investments	1,860,077,839	1,340,926,602
Total current assets	2,225,114,278	1,816,130,558
Board-designated assets and restricted cash		
Cash and cash equivalents	5,291,865	6,677,329
Investments	1,772,717,051	1,710,130,179
Restricted collateral	546,000	-
Restricted deposit	300,000	300,000
Total board-designated assets and restricted cash	1,778,854,916	1,717,107,508
Total cash, cash equivalents and investments	<u>\$ 4,003,969,194</u>	<u>\$ 3,533,238,066</u>

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

	2026	2025
Board-designated assets and restricted cash		
Contingency reserve fund	\$ 1,778,008,916	\$ 1,716,807,508
Restricted collateral	546,000	-
Restricted deposit with DMHC	300,000	300,000
	<u>\$ 1,778,854,916</u>	<u>\$ 1,717,107,508</u>

Custodial credit risk deposits – Custodial credit risk is the risk that, in the event of a bank failure, the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2026 and 2025, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

Investments – CalOptima Health invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds and mortgage- or asset-backed securities.

Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima Health manages its exposure to declines in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima Health's expected cash flow draws. The investment policy limits maturities to five years, while also staggering maturities. CalOptima Health maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes.

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As of June 30, 2026 and 2025, CalOptima Health's investments, including cash equivalents had the following modified duration:

Investment Type	June 30, 2026			
	Fair Value	Investment Maturities (in Years)		
		Less Than 1	1–5	More Than 5
U.S. Treasury notes	\$1,371,829,186	\$ 267,447,522	\$1,104,381,664	\$ -
U.S. Agency notes	129,113,460	-	129,113,460	-
Corporate bonds	926,114,429	27,739,140	898,375,289	-
Asset-backed securities	316,513,399	-	316,513,399	-
Mortgage-backed securities	549,353,836	13,630,735	535,723,101	-
Municipal bonds	79,830,461	2,010,308	77,820,153	-
Government-related	2,859,569	-	2,859,569	-
Commercial paper	82,418,550	82,418,550	-	-
Certificates of deposit	148,287,382	138,301,160	9,986,222	-
Cash equivalents	298,818,797	298,818,797	-	-
Cash	15,244,311	15,244,311	-	-
	<u>\$3,920,383,380</u>	<u>\$ 845,610,523</u>	<u>\$3,074,772,857</u>	<u>\$ -</u>
Accrued interest receivable	<u>26,474,621</u>			
	<u><u>\$3,946,858,001</u></u>			

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June 30, 2025				
Investment Type	Fair Value	Investment Maturities (in Years)		
		Less Than 1	1–5	More Than 5
U.S. Treasury notes	\$1,056,051,175	\$ 91,981,484	\$ 964,069,691	\$ -
U.S. Agency notes	100,608,023	-	100,608,023	-
Corporate bonds	955,165,722	47,590,754	907,574,968	-
Asset-backed securities	265,439,326	13,414,645	252,024,681	-
Mortgage-backed securities	377,695,982	4,129,370	373,566,612	-
Municipal bonds	93,903,321	19,315,252	74,588,069	-
Government-related	2,861,711	-	2,861,711	-
Commercial paper	76,139,294	76,139,294	-	-
Certificates of deposit	102,167,795	79,670,538	22,497,257	-
Cash equivalents	365,324,032	365,324,032	-	-
Cash	13,341,197	13,341,197	-	-
	<u>\$3,408,697,578</u>	<u>\$ 710,906,566</u>	<u>\$2,697,791,012</u>	<u>\$ -</u>
Accrued interest receivable	<u>21,024,431</u>			
	<u>\$3,429,722,009</u>			

Investments with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima Health portfolios are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima Health's investments included the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above as of June 30:

	2026	2025
Asset-backed securities	\$ 316,513,399	\$ 265,439,326
Mortgage-backed securities	549,353,836	377,695,982
	<u>\$ 865,867,235</u>	<u>\$ 643,135,308</u>

Credit risk – CalOptima Health's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor's Corporation (S&P), Moody's Investor Service (Moody's), and Fitch Ratings (Fitch). For an issuer of short-term debt, the rating must be no less than A-1 (S&P), P-1 (Moody's), or F-1 (Fitch), while an issuer of long-term debt shall be rated no less than A.

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As of June 30, 2026, the credit ratings of investments and cash equivalents were as follows:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA or A1/P1	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	\$ 1,457,359,991	N/A	\$ 1,457,359,991	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
U.S. Agency notes	130,158,273	N/A	130,158,273	-	-	-	-	-	-
Corporate bonds	935,475,883	A-	-	14,454,606	65,409,120	196,415,209	248,985,128	260,421,067	149,790,753
Supranational	2,984,475	AA	-	2,984,475	-	-	-	-	-
Asset-backed securities	317,036,283	AA	-	262,920,260	54,116,023	-	-	-	-
Mortgage-backed securities	550,546,372	AA	-	478,596,656	71,949,716	-	-	-	-
Municipal bonds	84,340,861	A-	-	24,206,114	38,965,877	7,764,838	6,570,397	6,833,635	-
Repurchase agreement	10,001,008	A-1	-	-	-	-	-	10,001,008	-
Certificates of deposit	158,462,342	A1/P1	-	81,545,024	-	76,917,318	-	-	-
Commercial paper	285,248,202	A-1	-	25,755,518	124,861,924	74,690,860	-	59,939,900	-
Money market mutual funds	15,244,311	AAA	-	15,244,311	-	-	-	-	-
Total	\$ 3,946,858,001		\$ 1,587,518,264	\$ 905,706,964	\$ 355,302,660	\$ 355,788,225	\$ 255,555,525	\$ 337,195,610	\$ 149,790,753

As of June 30, 2025, the credit ratings of investments and cash equivalents were as follows:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA or A1/P1	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	\$ 1,232,188,052	N/A	\$ 1,232,188,052	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
U.S. Agency notes	101,249,488	N/A	101,249,488	-	-	-	-	-	-
Corporate bonds	964,913,168	A-	-	41,172,765	65,791,623	148,143,887	195,576,926	310,128,062	204,099,905
Supranational	2,986,618	A-	-	2,986,618	-	-	-	-	-
Asset-backed securities	265,906,046	AA-	-	259,687,225	6,218,821	-	-	-	-
Mortgage-backed securities	378,464,085	AA-	-	327,529,570	50,934,515	-	-	-	-
Municipal bonds	108,132,906	A-	-	54,909,648	27,573,623	5,087,446	456,838	3,774,131	16,331,220
Certificates of deposit	102,676,170	A1/P1	-	102,676,170	-	-	-	-	-
Commercial paper	259,864,279	A1	-	85,355,082	-	8,026,305	18,960,096	147,522,769	-
Money market mutual funds	13,341,197	AAA	-	13,341,197	-	-	-	-	-
Total	\$ 3,429,722,009		\$ 1,333,437,540	\$ 887,658,275	\$ 150,518,582	\$ 161,257,638	\$ 214,993,860	\$ 461,424,962	\$ 220,431,125

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima Health's investment in a single issuer. CalOptima Health's investment policy limits no more than 5% of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises, and no more than 10% may be invested in one money market mutual fund. As of June 30, 2026 and 2025, all holdings complied with the foregoing limitations.

The Organization categorizes its fair value investments within the fair value hierarchy established by U.S. GAAP. The hierarchy for fair value measurements is based upon the observability of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

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The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy. The following table presents the fair value measurements of assets recognized in the accompanying statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

Investment Assets at Fair Value as of June 30, 2026				
	Level 1	Level 2	Level 3	Total
U.S. Treasury Notes	\$ 1,371,829,186	\$ -	\$ -	\$ 1,371,829,186
U.S. Agencies	-	129,113,460	-	129,113,460
Corporate bonds	-	926,114,429	-	926,114,429
Asset-backed securities	-	316,513,399	-	316,513,399
Mortgaged-backed securities	-	549,353,836	-	549,353,836
Municipal bonds	-	79,830,461	-	79,830,461
Government-related	-	2,859,569	-	2,859,569
Commercial paper	-	82,418,550	-	82,418,550
Certificates of deposit	-	148,287,382	-	148,287,382
	<u>\$ 1,371,829,186</u>	<u>\$ 2,234,491,086</u>	<u>\$ -</u>	<u>\$ 3,606,320,272</u>

Investment Assets at Fair Value as of June 30, 2025				
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	\$ 1,056,051,175	\$ -	\$ -	\$ 1,056,051,175
U.S. Agency notes	-	100,608,023	-	100,608,023
Corporate bonds	-	955,165,722	-	955,165,722
Asset-backed securities	-	265,439,326	-	265,439,326
Mortgage-backed securities	-	377,695,982	-	377,695,982
Municipal bonds	-	93,903,321	-	93,903,321
Government-related	-	2,861,711	-	2,861,711
Commercial paper	-	76,139,294	-	76,139,294
Certificates of deposit	-	102,167,795	-	102,167,795
	<u>\$ 1,056,051,175</u>	<u>\$ 1,973,981,174</u>	<u>\$ -</u>	<u>\$ 3,030,032,349</u>

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Note 4 – Capital Assets

Capital assets activity during the fiscal year ended June 30, 2026, consisted of the following:

	June 30, 2025	Additions	Retirements	Transfers	June 30, 2026
Capital assets not being depreciated					
Land	\$ 15,439,067	\$ -	\$ -	\$ -	\$ 15,439,067
Construction in progress	6,611,588	15,320,041	-	(16,741,105)	5,190,524
Total assets not being depreciated	22,050,655	15,320,041	-	(16,741,105)	20,629,591
Capital assets being depreciated					
Furniture and equipment	9,802,454	-	-	1,339,159	11,141,613
Computers and software	37,909,371	-	-	8,010,339	45,919,710
Leasehold improvements	5,293,622	-	-	189,813	5,483,435
Building	74,188,171	-	-	7,201,794	81,389,965
Subscription assets	38,939,942	17,275,231	(7,018,486)	-	49,196,687
	166,133,560	17,275,231	(7,018,486)	16,741,105	193,131,410
Less: accumulated depreciation for					
Furniture and equipment	8,327,574	567,864	-	-	8,895,438
Computers and software	29,360,597	5,816,656	-	-	35,177,253
Leasehold improvements	5,123,409	85,058	-	-	5,208,467
Building	26,660,547	3,061,570	-	-	29,722,117
Subscription assets	20,089,382	11,416,431	(7,018,486)	-	24,487,327
	89,561,509	20,947,579	(7,018,486)	-	103,490,602
Total depreciable assets, net	76,572,051	(3,672,348)	-	16,741,105	89,640,808
Capital assets, net	\$ 98,622,706	\$ 11,647,693	\$ -	\$ -	\$ 110,270,399
Subscription assets, net	\$ 18,850,560	\$ 5,858,800	\$ -	\$ -	\$ 24,709,360
Capital assets, net of subscription assets	\$ 79,772,146	\$ 5,788,893	\$ -	\$ -	\$ 85,561,039

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Capital asset activity during the fiscal year ended June 30, 2025, consisted of the following:

	June 30, 2024	Additions	Retirements	Transfers	June 30, 2025
Capital assets not being depreciated					
Land	\$ 15,439,067	\$ -	\$ -	\$ -	\$ 15,439,067
Construction in progress	8,062,076	6,131,045	-	(7,581,533)	6,611,588
Total assets not being depreciated	23,501,143	6,131,045	-	(7,581,533)	22,050,655
Capital assets being depreciated					
Furniture and equipment	9,478,750	-	(401,878)	725,582	9,802,454
Computers and software	40,527,864	-	(9,479,889)	6,861,396	37,909,371
Leasehold improvements	5,312,542	-	(13,475)	(5,445)	5,293,622
Building	69,053,311	5,134,860	-	-	74,188,171
Subscription assets	30,372,133	8,538,377	29,432	-	38,939,942
	154,744,600	13,673,237	(9,865,810)	7,581,533	166,133,560
Less: accumulated depreciation for					
Furniture and equipment	8,007,586	721,866	(401,878)	-	8,327,574
Computers and software	33,795,436	5,045,050	(9,479,889)	-	29,360,597
Leasehold improvements	5,101,443	35,441	(13,475)	-	5,123,409
Building	23,699,000	2,961,547	-	-	26,660,547
Subscription assets	11,081,464	8,978,486	29,432	-	20,089,382
	81,684,929	17,742,390	(9,865,810)	-	89,561,509
Total depreciable assets, net	73,059,671	(4,069,153)	-	7,581,533	76,572,051
Capital assets, net	\$ 96,560,814	\$ 2,061,892	\$ -	\$ -	\$ 98,622,706
Subscription assets, net	\$ 19,290,669	\$ (440,109)	\$ -	\$ -	\$ 18,850,560
Capital assets, net of subscription assets	\$ 77,270,145	\$ 2,502,001	\$ -	\$ -	\$ 79,772,146

The Organization recognized depreciation expense related to capital assets, exclusive of subscription assets of approximately \$9,531,000 and \$8,764,000 during the fiscal years ended June 30, 2026 and 2025, respectively. During the fiscal years ended June 30, 2026 and 2025, depreciation expense of approximately \$138,000 and \$122,000, respectively, is included within PACE medical expenses on the accompanying statements of revenues, expenses, and changes in net position. The Organization recognized depreciation expense related to subscription assets of approximately \$11,416,000 and \$9,008,000 during the fiscal years ended June 30, 2026 and 2025, respectively.

Note 5 – Medical Claims Liability

Medical claims liability consisted of the following as of June 30:

	2026	2025
Claims payable or pending approval	\$ 10,370,789	\$ 24,135,099
Provisions for IBNR claims	333,321,429	358,538,240
	<u>\$ 343,692,218</u>	<u>\$ 382,673,339</u>

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The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been IBNR. CalOptima Health estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the medical claims liability for the years ended June 30:

	<u>2026</u>	<u>2025</u>
Beginning balance	\$ 382,673,339	\$ 369,433,596
Incurred		
Current	2,575,391,957	2,495,023,707
Prior	<u>(138,237,762)</u>	<u>(110,308,536)</u>
	<u>2,437,154,195</u>	<u>2,384,715,171</u>
Paid		
Current	2,231,699,739	2,112,350,368
Prior	<u>244,435,577</u>	<u>259,125,060</u>
	<u>2,476,135,316</u>	<u>2,371,475,428</u>
Ending balance	<u><u>\$ 343,692,218</u></u>	<u><u>\$ 382,673,339</u></u>

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior-reporting-period liability. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated. The results included a decrease of prior-year incurred of approximately \$138,097,000 and \$110,309,000 for the fiscal years ended June 30, 2026 and 2025, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

The amounts accrued in the due to the State of California and CMS line item represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal rates issued by DHCS. DHCS continues to process the recoupments, and the remaining overpayments not yet recouped are included within the due to the State of California and CMS line item on the statements of net position.

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Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima Health's defined benefit pension plan, the CalPERS Plan, provides retirement and disability benefits, annual cost-of-living adjustments (COLAs), and death benefits to plan members and/or beneficiaries. The CalPERS Plan is part of the public agency portion of CalPERS, an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the State. Optional contract provisions are available through the California Public Employees' Retirement Law (PERL). CalOptima Health selects optional benefit provisions by contracting with CalPERS and adopting those benefits through Board of Directors approval (See "Benefits provided" below for more details). CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, California 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual COLAs, and death benefits to plan members, who must be public employees and/or beneficiaries. Pension benefits are based on plan members' years of service, age, and final compensation (three-year average) at the time of retirement. Members with five years of total service are eligible to retire at age 50 (Classic Member) or age 52 (New Member) with statutorily reduced benefits. All members are eligible for non-duty disability benefits if they have at least five years of service credit. Optional provisions elected by CalOptima Health include a 3% Cost of Living Allowance (Section 21335), 1959 Survivor Benefit Level 3 (Section 21573), \$5,000 Retired Death Benefit (Section 21623.5), 3-Year Final Compensation Period (Section 20037), Pre-Retirement Death Benefits to Continue After Remarriage of Survivor (Section 21551), and service credit purchase options for military and peace corps service (Section 21024 and 21023.5, respectively).

The CalPERS Plan's provisions and benefits in effect as of June 30, 2026, are summarized as follows:

Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2 % at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	Monthly for life	Monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible	1.092%-2.418%	1.0% to 2.5%
Required employee contribution rates	7.00%	8.25%
Required employer contribution rates	8.84%	8.84%

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The following is a summary of plan participants:

	June 30, 2026	June 30, 2025
Active employees	1,664	1,657
Retirees and beneficiaries Receiving benefits	314	277
Deferred retirement benefits		
Terminated employees	1,075	1,130
Surviving spouses	8	8
Beneficiaries	3	3

Contributions – Section 20814(c) of the California PERL requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall become effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The active employee contribution rate was 8.25% (PEPRA New Members) and 7.00% (Classic Members) of annual pay for both the fiscal years ended June 30, 2026 and 2025. The employer's contribution rate is 8.84% and 8.80% of annual payroll for the years ended June 30, 2026 and 2025, respectively.

CalOptima Health's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2025 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2024, total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions:

Valuation date	June 30, 2024
Measurement date	June 30, 2025
Actuarial cost method	Entry Age Normal
Actuarial assumptions	
Discount rate	6.90%
Inflation	2.30%
Salary increases	Varies by Entry Age and Service
Investment rate of return	6.8% Net of Pension Plan Investment and Administrative Expenses; Includes Inflation
Mortality rate table	Derived using CalPERS' Membership data for all funds
Post-retirement benefit increase	Contract COLA up to 2.30% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.30% thereafter

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The mortality table used was developed based on CalPERS-specific data. The probabilities of mortality are based on the 2021 CalPERS Experience Study for the period from 2001 to 2019. Pre-retirement and post-retirement mortality rates include generational mortality improvement using 80% of Scale MP-2020 published by the Society of Actuaries. For more details on this table, please refer to the CalPERS Experience Study and Review of Actuarial Assumptions report from November 2021 that can be found on the CalPERS website.

Changes in the net pension liability (asset) during the fiscal year ended June 30, 2026, were as follows:

	Increase (Decrease)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2025	\$ 379,032,159	\$ 373,191,167	\$ 5,840,992
Changes during the year			
Service cost	26,676,466	-	26,676,466
Interest on the total pension liability	27,522,114	-	27,522,114
Differences between expected and actual experience	10,195,597	-	10,195,597
Contributions from the employer	-	14,807,785	(14,807,785)
Contributions from employees	-	13,364,705	(13,364,705)
Net investment income	-	46,398,440	(46,398,440)
Benefit payments, including refunds of employee contributions	(7,389,543)	(7,389,543)	-
Administrative expenses	-	(266,680)	266,680
Net changes during the year	57,004,634	66,914,707	(9,910,073)
Balance at June 30, 2026	<u>\$ 436,036,793</u>	<u>\$ 440,105,874</u>	<u>\$ (4,069,081)</u>

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Changes in the net pension liability during the fiscal year ended June 30, 2025, were as follows:

	Increase (Decrease)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2024	\$ 317,035,251	\$ 271,053,892	\$ 45,981,359
Changes during the year			
Service cost	24,542,761	-	24,542,761
Interest on the total pension liability	23,886,852	-	23,886,852
Differences between expected and actual experience	20,191,968	-	20,191,968
Contributions from the employer	-	66,553,158	(66,553,158)
Contributions from employees	-	12,197,909	(12,197,909)
Net investment income	-	30,231,438	(30,231,438)
Benefit payments, including refunds of employee contributions	(6,624,673)	(6,624,673)	-
Administrative expenses	-	(220,557)	220,557
Net changes during the year	61,996,908	102,137,275	(40,140,367)
Balance at June 30, 2025	<u>\$ 379,032,159</u>	<u>\$ 373,191,167</u>	<u>\$ 5,840,992</u>

Discount rate and long-term rate of return – The discount rate used to measure the total pension liability was 6.90%. The projection of cash flows used to determine the discount rate assumed that contributions from plan members will be made at the current member contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the Organization's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which expected future real rates of return (i.e., expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations. Using historical returns of all of the funds' asset classes, expected compound (geometric) returns were calculated over the next 20 years using a building-block approach. The expected rate of return was then adjusted to account for assumed administrative expenses of 10 basis points.

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The table below reflects long-term expected real rate of return by asset class.

Asset Class	Assumed Return Allocation	Real Return ⁽¹⁾
Public Equity	37.0%	4.56%
Private Equity	17.0%	5.56%
Fixed Income	28.0%	2.53%
Real Assets	15.0%	3.03%
Private Debt	8.0%	4.93%
Strategic Leverage	-5.0%	1.40%

(1) Figures are based on the 2024 Mid-Cycle Asset Liability Management study.

(2) An expected annual rate of price inflation of 2.30% was used for this period.

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current rate:

	June 30, 2026		
	Current		
	Discount Rate -1%	Discount Rate	Discount Rate +1%
	5.90%	6.90%	7.90%
Net pension liability (asset)	\$ 70,585,148	\$ (4,069,081)	\$ (64,262,486)
	June 30, 2025		
	Current		
	Discount Rate -1%	Discount Rate	Discount Rate +1%
	5.90%	6.90%	7.90%
Net pension liability (asset)	\$ 71,146,769	\$ 5,840,992	\$ (46,772,150)

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Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima Health recognized pension expense of approximately \$18,688,000 and \$21,364,000 for the fiscal years ended June 30, 2026 and 2025, respectively. As of June 30, 2026 and 2025, CalOptima Health recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2026	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	\$ 1,886,033	\$ -
Net differences between projected and actual earnings on plan investments	-	(13,474,595)
Changes in assumptions	3,079,433	-
Differences between expected and actual experiences	24,960,547	(889,598)
	<u>\$ 29,926,013</u>	<u>\$ (14,364,193)</u>

	June 30, 2025	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	\$ 94,666	\$ -
Net differences between projected and actual earnings on plan investments	2,361,239	-
Changes in assumptions	4,311,207	-
Differences between expected and actual experiences	20,669,960	(1,321,519)
	<u>\$ 27,437,072</u>	<u>\$ (1,321,519)</u>

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The deferred outflows of resources related to employer contributions subsequent to the measurement date was recognized as a reduction of the net pension liability during the fiscal year ended June 30, 2026. The differences reported as deferred outflows and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

	Deferred Outflows and Inflows of Resources
Years Ending June 30,	
2027	\$ 8,250,499
2028	1,195,283
2029	375,651
2030	1,054,278
2031	2,632,933
Thereafter	167,143
	<u>\$ 13,675,787</u>

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima Health sponsors a deferred compensation plan created in accordance with IRC 457 (the 457 Plan) under which employees are permitted to defer a portion of their annual salary until future years. CalOptima Health may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the fiscal years ended June 30, 2026 and 2025, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima Health established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan (PARS Plan). CalOptima Health made discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. PARS vesting occurred over 16 quarters of service. Effective January 30, 2025, CalOptima Health transitioned the PARS plan to a 401(a) Defined Contribution plan administered by Empower. The balance and future contributions were transferred and allocated. Participation eligibility remains the same and CalOptima Health continues to make discretionary employer contributions with Board approval. The vesting schedule changed to a vested percentage of 25% per year over four years. For the fiscal years ended June 30, 2026 and 2025, CalOptima Health contributed approximately \$7,529,000 and \$6,858,000, respectively.

Note 8 – Postemployment Health Care Plan

Plan description – CalOptima Health sponsors and administers a single-employer defined-benefit postemployment healthcare plan (the Plan) to provide medical, dental, and vision insurance benefits to eligible retired employees and their beneficiaries. Plan members receiving benefits contribute at the same rate as current active employees. Benefit provisions are established and may be amended by the Board of Directors.

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Notes to Financial Statements**

Effective January 1, 2004, CalOptima Health terminated postemployment healthcare benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan. Surviving spouses are also eligible for this benefit.

During the fiscal year ended June 30, 2006, CalOptima Health modified the benefits offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima Health would be responsible only for the cost of Medicare supplemental coverage, subject to cost sharing between the participant and CalOptima Health.

For purposes of measuring the total postemployment retirement liability, deferred outflows of resources and deferred inflows of resources related to other postemployment benefits (OPEB), and OPEB expense, information about the fiduciary net position of CalOptima Health's plan (OPEB Plan) and additions to/deductions from the OPEB Plan's fiduciary net position have been determined on the same basis. For this purpose, benefit payments are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value.

U.S. GAAP requires that the reported results must pertain to liability and asset information within certain defined time frames. For this report, the following time frames are used:

Measurement date	June 30, 2025
Measurement period	July 1, 2024 - June 30, 2025
Valuation date	January 1, 2026

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

	2026	2025
Inactives currently receiving benefits	81	78
Active employees	50	53
Inactives entitled to but not yet receiving benefits	6	6
Total	137	137

Contributions – The contribution requirements of plan members and CalOptima Health are established and may be amended by the Board of Directors. CalOptima Health's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima Health contributed approximately \$721,000 for the fiscal year ended June 30, 2026. CalOptima Health contributed approximately \$637,000, which related to implied subsidies, for the fiscal year ended June 30, 2025. The most recent actuarial report for the Plan was June 30, 2025. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits was approximately \$15,772,000.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Notes to Financial Statements

Actuarial assumptions – CalOptima Health’s total OPEB liability was measured as of June 30, 2025, and the assumptions used to calculate the total OPEB liability were determined by an actuarial valuation dated January 1, 2026. The actuarial valuation was rolled forward to determine the total OPEB liability as of June 30, 2025, and is based on the following actuarial methods and assumptions:

Salary increases	2.75% per annum, in aggregate
Medical trend	Non-Medicare – 7.35% for 2027, decreasing to an ultimate rate of 3.45% in 2076 Medicare (Non-Kaiser) – 6.50% for 2027, decreasing to an ultimate rate of 3.45% in 2076 Medicare (Kaiser) – 5.45% for 2027, decreasing to an ultimate rate of 3.45% in 2076
Discount rate	5.20% at June 30, 2025, Bond Buyer 20 Index 3.93% at June 30, 2024, Bond Buyer 20 Index
Mortality, retirement	CalPERS 2000-2023 Experience Study Post-retirement mortality projected fully generational with Scale MP-2021
General inflation	2.50% per annum

Discount rate and long-term rate of return – The discount rate used to measure the total OPEB liability was 5.20% for June 30, 2025. There were no plan investments; as such, the expected long-term rate of return on investment is not applicable.

Changes in the net OPEB liability – Changes in the net OPEB liability during the fiscal years ended June 30, 2026 and 2025, were as follows:

Balance at June 30, 2025	<u>\$ 17,249,000</u>
Changes for the year	
Service cost	345,000
Interest	679,000
Actual vs. expected experience	(1,590,000)
Assumption changes	(274,000)
Contributions – employer	<u>(637,000)</u>
Net changes	<u>(1,477,000)</u>
Balance at June 30, 2026	<u><u>\$ 15,772,000</u></u>

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Notes to Financial Statements**

Balance at June 30, 2024	<u>\$ 17,370,000</u>
Changes for the year	
Service cost	378,000
Interest	638,000
Assumption changes	(615,000)
Contributions – employer	<u>(522,000)</u>
Net changes	<u>(121,000)</u>
Balance at June 30, 2025	<u><u>\$ 17,249,000</u></u>

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability as of June 30, 2026, as well as what the net OPEB liability would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current discount rate:

	<u>1% Decrease (4.20%)</u>	<u>Current Rate (5.20%)</u>	<u>1% Increase (6.20%)</u>
Total OPEB liability	\$ 17,588,000	\$ 15,772,000	\$ 14,240,000

Sensitivity of the net OPEB liability to changes in health care cost trend rates – The following presents the net OPEB liability as of June 30, 2026, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are one percentage point lower or one percentage point higher than the current health care cost trend rates:

	<u>1% Decrease</u>	<u>Current Rate</u>	<u>1% Increase</u>
Total OPEB liability	\$ 14,008,000	\$ 15,772,000	\$ 17,846,000

**Orange County Health Authority, A Public Agency dba Orange
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Notes to Financial Statements**

For the fiscal years ended June 30, 2026 and 2025, CalOptima Health recognized a reduction to OPEB expense of approximately \$1,193,000 and \$2,733,000, respectively. As of June 30, 2026 and 2025, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	June 30, 2026	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	\$ -	\$ 1,910,000
Changes in assumptions	276,000	449,000
Employer contributions made subsequent to measurement date	721,000	-
Total	<u>\$ 997,000</u>	<u>\$ 2,359,000</u>

	June 30, 2025	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	\$ -	\$ 1,666,000
Changes in assumptions	552,000	1,322,000
Employer contributions made subsequent to measurement date	637,000	-
Total	<u>\$ 1,189,000</u>	<u>\$ 2,988,000</u>

The \$721,000 reported as deferred outflows of resources related to contributions subsequent to the June 30, 2025, measurement date was recognized as a reduction of the total OPEB liability during the fiscal year ended June 30, 2026.

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

Years Ending June 30,	Deferred Inflows and Outflows of Resources
2027	\$ (1,334,000)
2028	(688,000)
2029	<u>(61,000)</u>
	<u>\$ (2,083,000)</u>

**Orange County Health Authority, A Public Agency dba Orange
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Notes to Financial Statements**

The required schedule of changes in total OPEB liability and related ratios immediately following the notes to the financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima Health became a fully licensed health care service plan under the Act, as required by statutes governing the Healthy Families program. Under the Act, CalOptima Health is required to maintain and meet a minimum level of TNE as of June 30, 2026 and 2025, of \$134,332,567 and \$129,341,855, respectively. As of June 30, 2026 and 2025, the Organization was in compliance with its TNE requirement.

The Act further requires that CalOptima Health maintain a restricted deposit in the amount of \$300,000. CalOptima Health met this requirement as of June 30, 2026 and 2025.

Note 10 – Lease Commitments

CalOptima Health leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

	Minimum Lease Payments
Years Ending June 30,	
2027	\$ 710,210
2028	768,055
2029	791,097
2030	814,830
2031	839,275
Thereafter	425,839
	<u>\$ 4,349,306</u>

Rental expense under operating leases was approximately \$721,000 for the fiscal years ended June 30, 2026 and 2025.

Note 11 – Contingencies

Litigation – CalOptima Health is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima Health's financial position or results of operations.

**Orange County Health Authority, A Public Agency dba Orange
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CalOptima Health
Notes to Financial Statements**

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that CalOptima Health is in compliance with fraud- and abuse-related, as well as other applicable government laws and regulations. Compliance with such laws and regulations could be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Note 12 – Subscription-Based Information Technology Arrangements

CalOptima Health has several subscription contracts that expire at various dates through 2030, with some having certain renewal options. For those contracts where renewal options are reasonably certain to be exercised, CalOptima Health recognizes renewal option periods in the determinations of its intangible right-to-use subscription assets and subscription liabilities. CalOptima Health uses various rates ranging from 3.25% to 8.50% to determine the present value of the subscription liabilities. As of June 30, 2026 and 2025, CalOptima Health recognized approximately \$23,198,000 and \$17,812,000, respectively, in SBITA subscription liabilities.

The future subscription payments under SBITAs as of June 30, 2026, are as follows:

	Subscriptions		
	Principal	Interest	Total
Years Ending June 30,			
2027	\$ 12,340,996	\$ 1,144,777	\$ 13,485,773
2028	6,216,158	538,106	6,754,264
2029	4,347,986	228,977	4,576,963
2030	2,276,046	70,936	2,346,982
Total undiscounted cash flows	<u>\$ 25,181,186</u>	<u>\$ 1,982,796</u>	<u>\$ 27,163,982</u>
Less: present value discount			<u>3,965,591</u>
Total subscription liabilities			<u>\$ 23,198,391</u>

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Supplementary Information

**Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment
Integrated Medical Assistance dba CalOptima Health
Schedule of Changes in Net Pension (Asset) Liability and Related Ratios
Years Ended June 30**

	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017
Total pension liability										
Service cost	\$ 26,676,466	\$ 24,542,761	\$ 19,761,157	\$ 17,958,280	\$ 16,033,791	\$ 15,223,385	\$ 14,303,164	\$ 13,491,596	\$ 13,118,795	\$ 10,272,406
Interest	27,522,114	23,886,852	19,987,952	17,450,590	15,591,711	13,770,107	12,107,314	10,431,464	9,136,725	7,702,198
Differences between expected and actual experience	10,195,597	20,191,968	5,143,171	8,006,529	(477,252)	(405,662)	1,904,567	2,812,748	632,642	102,384
Changes in assumptions	-	-	-	(1,930,719)	-	-	-	(4,737,905)	9,163,547	-
Benefit payments, including refunds of employee contributions	(7,389,543)	(6,624,673)	(5,027,500)	(4,332,714)	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)
Net change in total pension liability	57,004,634	61,996,908	39,864,780	37,151,966	27,836,253	25,010,908	25,473,833	19,249,204	29,983,353	15,965,410
Total pension liability – beginning	379,032,159	317,035,251	277,170,471	240,018,505	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544
Total pension liability – ending	436,036,793	379,032,159	317,035,251	277,170,471	240,018,505	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954
Plan fiduciary net position										
Contributions – employer	14,807,785	66,553,158	14,017,949	11,688,269	10,742,812	9,608,656	8,661,466	7,588,200	5,234,580	3,787,544
Contributions – employee	13,364,705	12,197,909	10,478,979	8,634,939	7,981,938	7,518,241	6,853,391	6,213,420	5,793,911	4,951,820
Net investment income	46,398,440	30,231,438	15,053,200	(18,576,662)	42,647,021	8,189,430	9,377,613	10,225,467	11,496,425	498,498
Benefit payments, including refunds of employee contributions	(7,389,543)	(6,624,673)	(5,027,500)	(4,332,714)	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)
Other changes in fiduciary net position	(266,680)	(220,557)	(174,062)	(149,157)	(181,370)	(225,629)	(98,234)	(530,428)	(143,264)	(54,828)
Net change in fiduciary net position	66,914,707	102,137,275	34,348,566	(2,735,325)	57,878,404	21,513,776	21,953,024	20,747,960	20,313,296	7,071,456
Plan fiduciary net position – beginning	373,191,167	271,053,892	236,705,326	239,440,651	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735
Plan fiduciary net position – ending	440,105,874	373,191,167	271,053,892	236,705,326	239,440,651	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191
Plan net pension (asset) liability – ending	\$ (4,069,081)	\$ 5,840,992	\$ 45,981,359	\$ 40,465,145	\$ 577,854	\$ 30,620,005	\$ 27,122,873	\$ 23,602,064	\$ 25,100,820	\$ 15,430,763
Plan fiduciary net position as percentage of the total liability	100.93%	98.46%	85.50%	85.40%	99.76%	85.57%	85.51%	85.40%	82.38%	86.28%
Covered-employee payroll	\$ 162,463,251	\$ 149,196,116	\$ 120,641,983	\$ 109,836,572	\$ 103,913,095	\$ 98,088,822	\$ 91,587,145	\$ 85,764,390	\$ 80,217,654	\$ 68,583,296
Plan net pension liability as a percentage of covered-employee payroll	-2.50%	3.91%	38.11%	36.84%	0.56%	31.22%	29.61%	27.52%	31.29%	22.50%

See report of independent auditors.

**Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment
Integrated Medical Assistance dba CalOptima Health
Schedule of Plan Contributions
Years Ended June 30**

	Years Ended June 30,									
	2026	2025	2024	2023	2022	2021	2020	2019	2018	2017
Actuarially determined contributions	\$ 14,807,785	\$ 16,553,441	\$ 14,017,949	\$ 11,688,269	\$ 10,742,812	\$ 9,608,656	\$ 8,661,466	\$ 7,588,200	\$ 5,234,580	\$ 3,787,544
Contributions in relation to the actuarially determined contribution	(14,807,785)	(66,553,158)	(14,017,949)	(11,688,269)	(10,742,812)	(9,608,656)	(8,661,466)	(7,588,200)	(5,234,580)	(3,787,544)
Contribution deficiency (excess)	\$ -	\$ (49,999,717)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Covered-employee payroll	\$ 162,463,251	\$ 149,196,116	\$ 120,641,983	\$ 109,836,572	\$ 103,913,095	\$ 98,088,822	\$ 91,587,145	\$ 85,764,390	\$ 80,217,654	\$ 68,583,296
Contributions as a percentage of covered-employee payroll	9.11%	11.10%	11.62%	10.64%	10.34%	9.80%	9.46%	8.85%	6.53%	5.52%

See report of independent auditors.

**Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment
Integrated Medical Assistance dba CalOptima Health
Schedule of Changes in Total OPEB Liability and Related Ratios
Periods Ended June 30**

	2025-2026 (Measurement Period 2024–2025)	2024-2025 (Measurement Period 2023–2024)	2023-2024 (Measurement Period 2022–2023)	2022-2023 (Measurement Period 2021–2022)	2021-2022 (Measurement Period 2020–2021)	2020-2021 (Measurement Period 2019–2020)	2019–2020 (Measurement Period 2018–2019)	2018–2019 (Measurement Period 2017–2018)	2017–2018 (Measurement Period 2016–2017)
Changes in total OPEB liability									
Service cost	\$ 345,000	\$ 378,000	\$ 472,000	\$ 668,000	\$ 1,149,000	\$ 811,000	\$ 832,000	\$ 867,000	\$ 1,012,000
Interest	679,000	638,000	679,000	487,000	718,000	922,000	977,000	900,000	770,000
Actual vs. expected experience	(1,590,000)	-	(3,332,000)	-	(6,241,000)	-	(1,072,000)	-	-
Assumption changes	(274,000)	(615,000)	1,104,000	(3,829,000)	(4,514,000)	4,623,000	938,000	(1,067,000)	(2,923,000)
Benefit payments	(637,000)	(522,000)	(528,000)	(529,000)	(544,000)	(570,000)	(556,000)	(560,000)	(572,000)
Net changes	(1,477,000)	(121,000)	(1,605,000)	(3,203,000)	(9,432,000)	5,786,000	1,119,000	140,000	(1,713,000)
Total OPEB liability (beginning of year)	17,249,000	17,370,000	18,975,000	22,178,000	31,610,000	25,824,000	24,705,000	24,565,000	26,278,000
Total OPEB liability (end of year)	<u>\$ 15,772,000</u>	<u>\$ 17,249,000</u>	<u>\$ 17,370,000</u>	<u>\$ 18,975,000</u>	<u>\$ 22,178,000</u>	<u>\$ 31,610,000</u>	<u>\$ 25,824,000</u>	<u>\$ 24,705,000</u>	<u>\$ 24,565,000</u>
Total OPEB liability	\$ 15,772,000	\$ 17,249,000	\$ 17,370,000	\$ 18,975,000	\$ 22,178,000	\$ 31,610,000	\$ 25,824,000	\$ 24,705,000	\$ 24,565,000
Covered-employee payroll	8,088,069	8,283,000	8,536,000	8,864,000	9,126,000	8,513,000	8,353,000	8,150,000	9,135,000
Total OPEB liability as a percentage of covered-employee payroll	195.0%	208.2%	203.5%	214.1%	243.0%	371.3%	309.2%	303.1%	268.9%

See report of independent auditors.

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CalOptima Health

2026 Audit Results

Discussion with the Board of
Directors (the “Board”)

October 1, 2026

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Agenda

1. Scope of Services
2. Summary of Audit Process
3. Significant Risks Identified
4. Matters to Be Communicated to the Governing Body
5. Your Service Team



Scope of Services

We have performed the following services for CalOptima Health:

Annual Audit

Annual financial statement audit as of and for the year ended June 30, 2026.

Non-Attest Services

- Assisted management with drafting the financial statements, excluding Management's Discussion and Analysis, as of and for the year ended June 30, 2026.
- Assisting in the completion of the Auditee portion of the Data Collection Form for the single audit as of and for the year ended June 30, 2026.



Summary of Audit Process

Our audit was generally performed in accordance with our initial plan. When the results of a planned audit procedure did not provide sufficient evidence or our original plan was based on an incorrect understanding of a transaction, process, or accounting policy of the entity, we made the necessary adjustments to our audit plan to incorporate the procedures necessary to support our opinion on the financial statements.

We have completed our testing of all significant account balances and classes of transactions.

We will issue our independent auditor's report and communicate required internal control related matters on October 1, 2026.

The 2026 OMB Compliance Supplement has not yet been issued. The financial statement audit has been completed on October 1, 2026; however, completion of the Single Audit is dependent upon issuance of the 2026 Compliance Supplement and completion of the related audit procedures.



Significant Risks Identified

During the planning of the audit we have identified the following significant risks:

Significant Risks	Procedures
Medical claims liability and claims expense	• Tested the internal controls for claims payments and provider capitation systems • Tested the data used by the actuary to estimate the claims liability and reviewed the experience and qualifications of the actuary • Performed a retrospective review of the prior year’s claims liability • No exceptions noted for the procedures performed
Capitation revenue and receivables	• Developed independent expectations of revenue using membership data and rates • Obtained an understanding of management’s reserve methodology and validated key inputs through our audit procedures • Verified subsequent receipt of cash and other substantive procedures • No exceptions noted for the procedures performed
Amounts due to the State of California or DHCS	• Tested the provider capitation and other accrual calculations and agreed amounts accrued to subsequent payments • Obtained an understanding of the nature of the amounts payable to the State of California • Tested inputs into the estimates used to calculate the amounts due • No exceptions noted for the procedures performed



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) as well as *Government Auditing Standards*, issued by the Comptroller General of the United States. As part of an audit conducted in accordance with these auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

Our audit of the financial statements included obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Our consideration of internal control was not designed to identify all deficiencies that might be material weaknesses or significant deficiencies. During our audit, we did not identify any deficiencies in internal control that we consider to be material weaknesses; however, material weaknesses or significant deficiencies may exist that were not identified.



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.



Matters to Be Communicated to the Governing Body

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

Baker Tilly Comments

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

- Significant management estimates that impacted the financial statements include the following: **fair value of investments, capital asset lives, actuarially determined accruals for incurred but not reported (IBNR) medical claims liabilities, other non-IBNR medical liabilities, pension, and other postemployment liabilities.**

Matters to Be Communicated to the Governing Body

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

Baker Tilly Comments

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

- Note 2 – Summary of Significant Accounting Policies
- Note 3 – Cash, Cash Equivalents, and Investments
- Note 5 – Medical Claims Liability
- Note 6 – Defined Benefit Pension Plan
- Note 8 – Postemployment Health Care Plan

Matters to Be Communicated to the Governing Body

Significant Changes – GASB

Statement	Title	Effective
No. 103	<i>Financial Reporting Model Improvements</i> – The objective of this Statement is to improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government’s accountability. This Statement also addresses certain application issues. CalOptima Health adopted GASB 103 during the year ending June 30, 2026. The adoption resulted in changes to certain financial statement presentation and disclosures but did not have a material impact on the amounts reported in the financial statements.	Fiscal years beginning after June 15, 2025 (Effective for FY26).
No. 104	<i>Disclosure of Certain Capital Assets</i> – State and local governments are required to provide detailed information about capital assets in notes to financial statements. Statement No. 34, Basic Financial Statements— and Management’s Discussion and Analysis—for State and Local Governments, requires certain information regarding capital assets to be presented by major class. CalOptima Health adopted GASB 104 during the year ending June 30, 2026. The adoption resulted in changes to the capital asset disclosures but did not have a material impact on the amounts reported in the financial statements.	Fiscal years beginning after June 15, 2025 (Effective for FY26).



Matters to Be Communicated to the Governing Body

Significant Unusual Transactions:

Baker Tilly Comments

No significant unusual transactions were identified during our audit of the entity's financial statements.

Matters to Be Communicated to the Governing Body

Significant Difficulties Encountered During the Audit:

We are to inform those charged with governance of any significant difficulties encountered in performing the audit. Examples of difficulties may include significant delays by management, an unreasonably brief time to complete the audit, unreasonable management restrictions encountered by the auditor or an unexpected extensive effort required to obtain sufficient appropriate audit evidence.

Baker Tilly Comments

No significant difficulties were encountered during our audit of the entity's financial statements.

Matters to Be Communicated to the Governing Body

Disagreements With Management:

Disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the entity's financial statements, or the auditor's report.

Baker Tilly Comments

There were no disagreements with management.

Matters to Be Communicated to the Governing Body

Circumstances that affect the form and content of the auditor's report:

Baker Tilly Comments

There were no circumstances that affected the form and content of the auditor's report.

Matters to Be Communicated to the Governing Body

Other findings or issues arising from the audit that are, in the auditor's professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process:

Baker Tilly Comments

There were no other findings or issues arising from the audit to report.

Matters to Be Communicated to the Governing Body

Uncorrected Misstatements:

Uncorrected misstatements, or matters underlying those uncorrected misstatements, as of and for the year ended June 30, 2026, could potentially cause future-period financial statements to be materially misstated.

Baker Tilly Comments

No uncorrected misstatements were identified.

Matters to Be Communicated to the Governing Body

Material, Corrected Misstatements:

Material, corrected misstatements that were brought to the attention of management as a result of audit procedures.

Baker Tilly Comments

No material misstatements were identified as a result of our audit.

Matters to Be Communicated to the Governing Body

Representations Requested of Management

We requested certain representations from management that are included in the management representation letter dated September 21, 2026

Baker Tilly Comments

A copy of the management representation letter is available upon request.

Matters to Be Communicated to the Governing Body

Management's Consultation with Other Accountants:

When we are aware that management has consulted with other accountants about significant auditing or accounting matters, we discuss with those charged with governance our views about the matters that were the subject of such consultation.

Baker Tilly Comments

We are not aware of instances where management consulted with other accountants about significant auditing or accounting matters.



Matters to Be Communicated to the Governing Body

Significant issues arising from the audit that were discussed, or the subject of correspondence with management:

Baker Tilly Comments

No significant issues arose during the audit that have not been addressed elsewhere in this presentation.

Matters to Be Communicated to the Governing Body

AU-C 240, Consideration of Fraud in a Financial Statement Audit

AU-C 250, Consideration of Laws and Regulations in an Audit of Financial Statements

AU-C 265, Communicating Internal Control Related Matters Identified in an Audit

AU-C 550, Related Parties

AU-C 560, Subsequent Events and Subsequently Discovered Facts

AU-C 570, The Auditor's Consideration of An Entity's Ability to Continue as a Going Concern

AU-C 600, Audits of Group Financial Statements (Including the Work of Component Auditors)

Baker Tilly Comments

Nothing to note.

- There were no material weaknesses noted and no significant deficiencies to communicate.

Matters to Be Communicated to the Governing Body

AU-C 701, *Communicating Key Audit Matters in the Independent Auditor's Report*

AU-C 705, *Modifications to the Opinion in the Independent Auditor's Report*

AU-C 706, *Emphasis-of-Matter Paragraphs and Other-Matter Paragraphs in the Independent Auditor's Report*

AU-C 720, *The Auditor's Responsibilities Relating to Other Information Included in Annual Reports*

AU-C 730, *Required Supplementary Information*

AU-C 930, *Interim Financial Information*

AU-C 935, *Compliance Audits*

Baker Tilly Comments

Nothing to note.

Your Service Team



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*Audit Engagement
Reviewer*

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THANK YOU

[Back to Agenda](#)

[Back to Item](#)

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026 Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

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

Contact

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

Recommended Action

Approve the Revised CalOptima Health Medi-Cal Fiscal Year 2026-27 Operating Budget and authorize expenditures and appropriate funds for the items in Revised Attachment A: Revised Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items.

Background

On June 4, 2026, the CalOptima Health Board of Directors (Board) approved the Fiscal Year (FY) 2026-27 Budget, which provided forecasted revenue and spending for the period from July 1, 2026, through June 30, 2027 (June Operating Budget). At the time of approval, staff submitted a comprehensive budget for all lines of business using assumptions based on the best information available and committed to recommend budget revisions for the Board's consideration in the event of material policy, program, or funding changes.

Discussion

The Revised Medi-Cal FY 2026-27 Operating Budget (Revised Medi-Cal Operating Budget) addresses two material changes that require budget revisions to the second half of the current fiscal year (i.e., January 1, 2027, through June 30, 2027), which include the following:

- Transition of Unsatisfactory Immigration Status (UIS) members from the managed care delivery system to the fee-for-service (FFS) system: The FY 2026-27 Enacted State Budget included the transition of UIS members from Medi-Cal managed care to the FFS system, effective January 1, 2027.
- Delay in Private Hospital Directed Payment (PHDP) Program payment methodology transition: The 2024 Managed Care Final Rule prohibits the use of separate payment terms and requires all state directed payments to be included in actuarially sound, prospective capitation rates. H.R. 1 limits new state directed payments to 100% of Medicare rates and beginning in 2028, reduces "grandfathered" state directed payments by 10% per year until the Medicare cap is reached. The June Operating Budget assumed that the transition from separate payment terms to a risk-based prospective payment model would begin January 1, 2027. In July 2026, the Department of

Health Care Services announced that Calendar Year 2027 will serve as a transition year, with the full transition beginning January 1, 2028.

The following table compares the June Operating Budget and the proposed Revised Medi-Cal Operating Budget.

FY 2026-27 Medi-Cal Operating Budget

	FY 2026-27 Approved Budget	FY 2026-27 Revised Budget	\$ Change	% Change
Average Monthly Enrollment	719,232	668,561	(50,671)	-7.0%
Revenue	\$4,225,587,197	\$3,457,123,258	(\$768,463,939)	-18.2%
Medical Costs	\$3,957,666,037	\$3,207,352,064	(\$750,313,973)	-19.0%
Administrative Expenses	\$235,327,631	\$235,327,631	--	--
Operating Income/Loss	\$32,593,529	\$14,443,563	(\$18,149,966)	-55.7%
Medical Loss Ratio (MLR)	93.66%	92.78%	--	-0.88%
Administrative Loss Ratio (ALR)	5.57%	6.81%	--	1.24%

For more information on the budget at the consolidated level, please refer to Revised Attachment A: Revised FY 2026-27 Operating Budget for All Lines of Business and Non-Operating Items.

Revised Medi-Cal Operating Budget Analysis

Enrollment: The Revised Medi-Cal Operating Budget forecasts a 14.6% decrease in Medi-Cal enrollment for the period of January to June 2027 (decrease of 7.0% over 12 months). Staff took the historical forecast and adjusted for the anticipated enrollment decrease. Specifically, staff projects a decrease of 101,342 average members from January to June 2027 due to the UIS member transition.

Revenue: The Revised Medi-Cal Operating Budget reflects a 33.6% decrease in Medi-Cal revenue for the period of January to June 2027 (decrease of 18.2% over 12 months). Staff projects a revenue decrease of \$341.2 million from the UIS member transition and \$427.2 million from the PHDP payment methodology transition delay.

Medical Costs: The Revised Medi-Cal Operating Budget reflects a 34.8% decrease in Medi-Cal medical costs for the period of January to June 2027 (decrease of 19.0% over 12 months). Staff projects a decrease in medical costs of \$323.1 million from the UIS member transition and \$427.2 million from the PHDP Program payment methodology transition delay. As such, the revised budget proposes a 92.78% MLR.

Administrative Expenses: There were no changes made to the budget assumptions in the Revised Medi-Cal Operating Budget. Due to the changes in revenue mentioned above, the Administrative Loss Ratio was adjusted to 6.81%.

To the extent there are any other material changes to the budget, management will address such changes in separate Board actions or in future operating budgets.

Fiscal Impact

The Revised Medi-Cal Operating Budget changes the forecasted operating income from \$41.4 million to \$23.2 million at the consolidated level.

Rationale for Recommendation

Staff submits the Revised Medi-Cal Operating Budget to address material changes to CalOptima Health's forecasted enrollment, revenue, and medical costs for the Medi-Cal line of business.

Concurrence

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

Attachments

1. [Attachment A: FY 2026-27 Operating Budget for All Lines of Business and Non-Operating Items \(Approved by the Board on June 4, 2026\)](#)
2. [Revised Attachment A: Revised FY 2026-27 Operating Budget for All Lines of Business and Non-Operating Items](#)

Attachment A: Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items

	Medi-Cal	OneCare	PACE	CCA	MSSP	Facilities	Consolidated
Member Months	8,630,786	238,672	7,128	116,166	7,056	-	8,992,752
Avg Members	719,232	19,889	594	9,681	588	-	749,396
Revenue							
Capitation Revenue	\$ 4,225,587,197	\$ 488,226,827	\$ 66,015,079	\$ 76,624,656	\$ 3,149,328	\$ -	\$ 4,859,603,087
Total	\$ 4,225,587,197	\$ 488,226,827	\$ 66,015,079	\$ 76,624,656	\$ 3,149,328	\$ -	\$ 4,859,603,087
Medical Costs							
Provider Capitation	\$ 1,154,063,413	\$ 173,848,853	\$ -	\$ 10,937,325	\$ -	\$ -	\$ 1,338,849,590
Professional, Facility & Ancillary Claims	\$ 1,554,983,870	\$ 98,900,140	\$ 25,489,598	\$ 25,036,763	\$ -	\$ -	\$ 1,704,410,371
Managed Long-Term Services and Supports (MLTSS)	\$ 563,328,283	\$ -	\$ 1,496,573	\$ -	\$ 409,413	\$ -	\$ 565,234,269
Prescription Drugs	\$ -	\$ 134,160,544	\$ 8,028,509	\$ -	\$ -	\$ -	\$ 142,189,052
Other Medical	\$ 556,337,154	\$ 14,884,493	\$ 4,170,817	\$ 30,426,400	\$ -	\$ -	\$ 605,818,863
Medical Management	\$ 128,953,318	\$ 15,939,201	\$ 21,102,173	\$ 1,608,209	\$ 2,564,958	\$ -	\$ 170,167,859
Total	\$ 3,957,666,037	\$ 437,733,230	\$ 60,287,670	\$ 68,008,697	\$ 2,974,371	\$ -	\$ 4,526,670,005
MLR	93.66%	89.66%	91.32%	88.76%	94.44%		93.15%
Gross Margin	\$ 267,921,160	\$ 50,493,597	\$ 5,727,408	\$ 8,615,959	\$ 174,957	\$ -	\$ 332,933,082
Administrative Expenses							
Salaries, Wages, & Employee Benefits	\$ 141,230,337	\$ 15,004,548	\$ 2,498,603	\$ 3,737,791	\$ 1,409,792	\$ -	\$ 163,881,071
Non-Salary Operating Expenses	\$ 88,596,580	\$ 9,666,657	\$ 1,454,667	\$ 5,342,731	\$ 94,500	\$ 5,042,302	\$ 110,197,437
Depreciation & Amortization	\$ 13,392,714	\$ -	\$ 19,465	\$ 1,100,000	\$ -	\$ 2,500,000	\$ 17,012,179
Indirect Cost Allocation, Occupancy Expense	\$ (7,892,000)	\$ 14,455,000	\$ 217,120	\$ 1,155,572	\$ 94,000	\$ (7,542,302)	\$ 487,390
Total	\$ 235,327,631	\$ 39,126,205	\$ 4,189,855	\$ 11,336,094	\$ 1,598,292	\$ (0)	\$ 291,578,076
ALR	5.57%	8.01%	6.35%	14.79%	50.75%		6.00%
Operating Income/(Loss)	\$ 32,593,529	\$ 11,367,392	\$ 1,537,553	\$ (2,720,135)	\$ (1,423,335)	\$ 0	\$ 41,355,006
							0.85%
Provider Rate Increase							\$ (171,839,842)
Digital Transformation Strategy							\$ (5,400,000)
Covered California							\$ (7,747,961)
Non-Operating							
Net Investment Income							\$ 100,000,000
500 Building							\$ (1,043,542)
Street Medicine Support Center							\$ (1,020,535)
Total Non-Operating Income/(Loss)							\$ 97,935,923

Revised Attachment A: Revised Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items

	Medi-Cal	OneCare	PACE	CCA	MSSP	Facilities	Consolidated
Member Months	8,022,733	238,672	7,128	116,166	7,056	-	8,384,699
Avg Members	668,561	19,889	594	9,681	588	-	698,725
Revenue							
Capitation Revenue	\$ 3,457,123,258	\$ 488,226,827	\$ 66,015,079	\$ 76,624,656	\$ 3,149,328	\$ -	\$ 4,091,139,147
Total	<u>\$ 3,457,123,258</u>	<u>\$ 488,226,827</u>	<u>\$ 66,015,079</u>	<u>\$ 76,624,656</u>	<u>\$ 3,149,328</u>	<u>\$ -</u>	<u>\$ 4,091,139,147</u>
Medical Costs							
Provider Capitation	\$ 1,056,288,388	\$ 173,848,853	\$ -	\$ 10,937,325	\$ -	\$ -	\$ 1,241,074,566
Professional, Facility & Ancillary Claims	\$ 1,358,449,606	\$ 98,900,140	\$ 25,489,598	\$ 25,036,763	\$ -	\$ -	\$ 1,507,876,107
Managed Long-Term Services and Supports (MLTSS)	\$ 541,835,457	\$ -	\$ 1,496,573	\$ -	\$ 409,413	\$ -	\$ 543,741,443
Prescription Drugs	\$ -	\$ 134,160,544	\$ 8,028,509	\$ -	\$ -	\$ -	\$ 142,189,052
Other Medical	\$ 121,825,295	\$ 14,884,493	\$ 4,170,817	\$ 30,426,400	\$ -	\$ -	\$ 171,307,004
Medical Management	\$ 128,953,318	\$ 15,939,201	\$ 21,102,173	\$ 1,608,209	\$ 2,564,958	\$ -	\$ 170,167,859
Total	<u>\$ 3,207,352,064</u>	<u>\$ 437,733,230</u>	<u>\$ 60,287,670</u>	<u>\$ 68,008,697</u>	<u>\$ 2,974,371</u>	<u>\$ -</u>	<u>\$ 3,776,356,032</u>
MLR	92.78%	89.66%	91.32%	88.76%	94.44%		92.31%
Gross Margin	\$ 249,771,194	\$ 50,493,597	\$ 5,727,408	\$ 8,615,959	\$ 174,957	\$ -	\$ 314,783,116
Administrative Expenses							
Salaries, Wages, & Employee Benefits	\$ 141,230,337	\$ 15,004,548	\$ 2,498,603	\$ 3,737,791	\$ 1,409,792	\$ -	\$ 163,881,071
Non-Salary Operating Expenses	\$ 88,596,580	\$ 9,666,657	\$ 1,454,667	\$ 5,342,731	\$ 94,500	\$ 5,042,302	\$ 110,197,437
Depreciation & Amortization	\$ 13,392,714	\$ -	\$ 19,465	\$ 1,100,000	\$ -	\$ 2,500,000	\$ 17,012,179
Indirect Cost Allocation, Occupancy Expense	\$ (7,892,000)	\$ 14,455,000	\$ 217,120	\$ 1,155,572	\$ 94,000	\$ (7,542,302)	\$ 487,390
Total	<u>\$ 235,327,631</u>	<u>\$ 39,126,205</u>	<u>\$ 4,189,855</u>	<u>\$ 11,336,094</u>	<u>\$ 1,598,292</u>	<u>\$ (0)</u>	<u>\$ 291,578,076</u>
ALR	6.81%	8.01%	6.35%	14.79%	50.75%		7.13%
Operating Income/(Loss)	<u><u>\$ 14,443,563</u></u>	<u><u>\$ 11,367,392</u></u>	<u><u>\$ 1,537,553</u></u>	<u><u>\$ (2,720,135)</u></u>	<u><u>\$ (1,423,335)</u></u>	<u><u>\$ 0</u></u>	<u><u>\$ 23,205,039</u></u>
							0.57%
Provider Rate Increase							<u><u>\$ (171,839,842)</u></u>
Digital Transformation Strategy							<u><u>\$ (5,400,000)</u></u>
Covered California							<u><u>\$ (7,747,961)</u></u>
Non-Operating							
Net Investment Income							\$ 100,000,000
500 Building							\$ (1,043,542)
Street Medicine Support Center							\$ (1,020,535)
Total Non-Operating Income/(Loss)							<u><u>\$ 97,935,923</u></u>



CalOptima Health

Revised Medi-Cal Fiscal Year 2026-27 Operating Budget

**Board of Directors' Meeting
October 1, 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.

Agenda

- Two Material Medi-Cal Budget Revisions
 - Unsatisfactory Immigration Status (UIS) Member Transition
 - Enrollment: Trend and Forecast
 - Private Hospital Directed Payment (PHDP) Program Payment Methodology Transition Delay
- FY 2026-27 Revised Medi-Cal Budget
- FY 2026-27 Revised Consolidated Operating Budget
 - Revised Attachment A: Revised Consolidated Income Statement
- Recommended Action

Two Material Medi-Cal Budget Revisions (Effective Jan – June 2027)

Budget Revision	Anticipated Change from June Operating Budget
1. Effective 1/1/27: UIS members will transition from the managed care delivery system and move to Medi-Cal fee-for-service	▼ Enrollment ▼ Revenue ▼ Medical Costs
2. One-year delay to transition PHDP payments into managed care plans' prospective payments (changed from 1/1/27 to 1/1/28)	▼ Revenue ▼ Medical Costs

- Both revisions impact only the second half of the current fiscal year and are material enough to seek Board approval of a Revised CalOptima Health Medi-Cal FY 2026-27 Operating Budget

1. UIS Member Transition

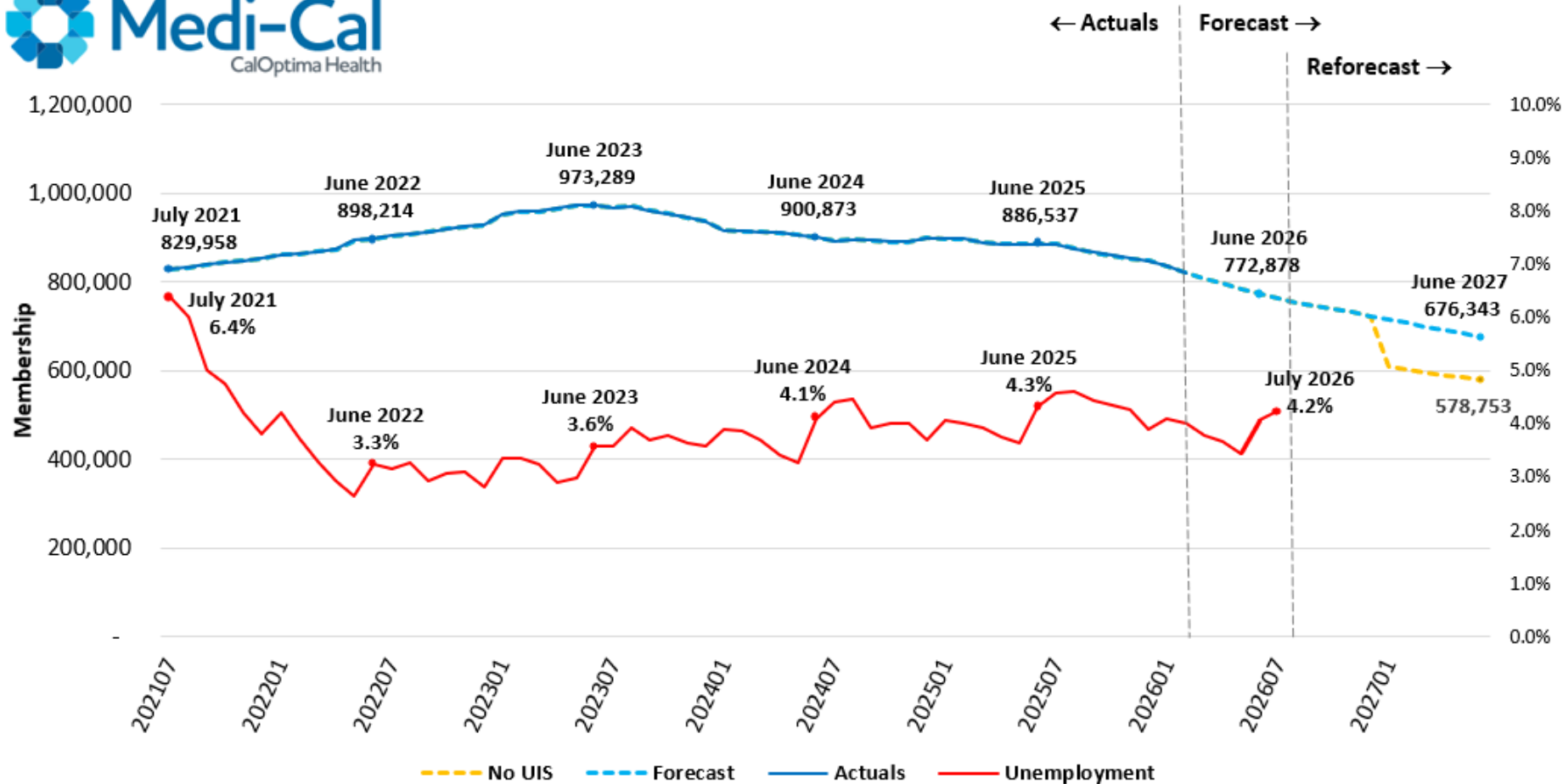
- Background

- Sept 2025: CMS released a new interpretation of federal law
- Requires DHCS to discontinue federal funded coverage of Medicaid emergency services for UIS members through Medi-Cal managed care
- 1/1/27: DHCS will transition all UIS members in the state to Medi-Cal FFS

- Estimated impact on Jan – June 2027 Budget:

- Enrollment: Decrease of 101,342 average members
- Revenue: Decrease of \$341.2 million
- Medical Cost: Decrease of \$323.1 million

Enrollment: Trend and Forecast



- Medi-Cal enrollment graph as presented at the 6/4/26 CalOptima Health Board of Directors meeting
- Data included in this report are based on member eligibility months rather than booked enrollment (as used in the financials)
- Includes data as of March 2026



2. PHDP Payment Methodology Transition Delay

○ Background

- 2024 Managed Care Final Rule: Requires that all State Directed Payments (SDP) be included in actuarially sound, prospective rates
 - Prohibits the use of separate payment terms for SDP and retroactive amendments to approvals
- H.R. 1: Beginning Calendar Year 2028, reduces “grandfathered” SDPs by 10% per year until they reach the Medicare cap (i.e., 100% of Medicare rates)
- July 2026: DHCS notified plans that the full transition of PHDP payments to capitation rates was delayed to 1/1/28

○ Estimated impact on Jan – June 2027 budget:

- Revenue: Decrease of \$427.2 million
- Medical Cost: Decrease of \$427.2 million

FY 2026-27 Revised Medi-Cal Budget

	FY 2026-27 June Approved Budget	FY 2026-27 Revised Budget*	Change (\$)	Change (%)
Average Monthly Enrollment	719,232	668,561	(50,671)	-7.0%
Revenue	\$4,225,587,197	\$3,457,123,258	(\$768,463,939)	-18.2%
Medical Costs	\$3,957,666,037	\$3,207,352,064	(\$750,313,973)	-19.0%
Administrative Expenses	\$235,327,631	\$235,327,631	--	--
Operating Income/Loss	\$32,593,529	\$14,443,563	(\$18,149,966)	-55.7%
MLR	93.66%	92.78%	--	-0.88%
ALR	5.57%	6.81%	--	1.24%

* Reflects budget changes from Jan - June 2027

FY 2026-27 Revised Consolidated Operating Budget

	FY 2026-27 June Approved Budget	FY 2026-27 Revised Budget
Average Enrollment*	749,396	698,725
Revenue	\$4,859,603,087	\$4,091,139,147
Medical Costs	\$4,526,670,005	\$3,776,356,032
<i>Medical Loss Ratio (MLR)</i>	93.15%	92.31%
Administrative Expenses	\$291,578,076	\$291,578,076
<i>Admin Loss Ratio (ALR)</i>	6.00%	7.13%
Operating Income/Loss	\$41,355,006 or 0.85%	\$23,205,039 or 0.57%

* Average enrollment reflects six months of Covered California operations

Revised Attachment A: Revised Consolidated Income Statement

	Medi-Cal	OneCare	PACE	CCA	MSSP	Facilities	Consolidated
Member Months	8,022,733	238,672	7,128	116,166	7,056	-	8,384,699
Avg Members	668,561	19,889	594	9,681	588	-	698,725
Revenue							
Capitation Revenue	\$ 3,457,123,258	\$ 488,226,827	\$ 66,015,079	\$ 76,624,656	\$ 3,149,328	\$ -	\$ 4,091,139,147
Total	\$ 3,457,123,258	\$ 488,226,827	\$ 66,015,079	\$ 76,624,656	\$ 3,149,328	\$ -	\$ 4,091,139,147
Medical Costs							
Provider Capitation	\$ 1,056,288,388	\$ 173,848,853	\$ -	\$ 10,937,325	\$ -	\$ -	\$ 1,241,074,566
Professional, Facility & Ancillary Claims	\$ 1,358,449,606	\$ 98,900,140	\$ 25,489,598	\$ 25,036,763	\$ -	\$ -	\$ 1,507,876,107
Managed Long-Term Services and Supports (MLTSS)	\$ 541,835,457	\$ -	\$ 1,496,573	\$ -	\$ 409,413	\$ -	\$ 543,741,443
Prescription Drugs	\$ -	\$ 134,160,544	\$ 8,028,509	\$ -	\$ -	\$ -	\$ 142,189,052
Other Medical	\$ 121,825,295	\$ 14,884,493	\$ 4,170,817	\$ 30,426,400	\$ -	\$ -	\$ 171,307,004
Medical Management	\$ 128,953,318	\$ 15,939,201	\$ 21,102,173	\$ 1,608,209	\$ 2,564,958	\$ -	\$ 170,167,859
Total	\$ 3,207,352,064	\$ 437,733,230	\$ 60,287,670	\$ 68,008,697	\$ 2,974,371	\$ -	\$ 3,776,356,032
MLR	92.78%	89.66%	91.32%	88.76%	94.44%		92.31%
Gross Margin	\$ 249,771,194	\$ 50,493,597	\$ 5,727,408	\$ 8,615,959	\$ 174,957	\$ -	\$ 314,783,116
Administrative Expenses							
Salaries, Wages, & Employee Benefits	\$ 141,230,337	\$ 15,004,548	\$ 2,498,603	\$ 3,737,791	\$ 1,409,792	\$ -	\$ 163,881,071
Non-Salary Operating Expenses	\$ 88,596,580	\$ 9,666,657	\$ 1,454,667	\$ 5,342,731	\$ 94,500	\$ 5,042,302	\$ 110,197,437
Depreciation & Amortization	\$ 13,392,714	\$ -	\$ 19,465	\$ 1,100,000	\$ -	\$ 2,500,000	\$ 17,012,179
Indirect Cost Allocation, Occupancy Expense	\$ (7,892,000)	\$ 14,455,000	\$ 217,120	\$ 1,155,572	\$ 94,000	\$ (7,542,302)	\$ 487,390
Total	\$ 235,327,631	\$ 39,126,205	\$ 4,189,855	\$ 11,336,094	\$ 1,598,292	\$ (0)	\$ 291,578,076
ALR	6.81%	8.01%	6.35%	14.79%	50.75%		7.13%
Operating Income/(Loss)	\$ 14,443,563	\$ 11,367,392	\$ 1,537,553	\$ (2,720,135)	\$ (1,423,335)	\$ 0	\$ 23,205,039
							0.57%
Provider Rate Increase							\$ (171,839,842)
Digital Transformation Strategy							\$ (5,400,000)
Covered California							\$ (7,747,961)
Non-Operating							
Net Investment Income							\$ 100,000,000
500 Building							\$ (1,043,542)
Street Medicine Support Center							\$ (1,020,535)
Total Non-Operating Income/(Loss)							\$ 97,935,923

Recommended Action

1. Approve the Revised CalOptima Health Medi-Cal Fiscal Year 2026-27 Operating Budget and authorize expenditures and appropriate funds for the items in Revised Attachment A: Revised Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items



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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Authorize 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.

Background and Discussion

Staff requests that CalOptima Health Board of Directors (Board) authorize the Chief Executive Officer (CEO), or designee, to execute an amendment to CalOptima Health's contract with the Orange County Health Care Agency (County), effective January 1, 2027. The contract, which coordinates public health benefits and services provided jointly between CalOptima Health and the County and reimburses the County for CalAIM program services, expires on December 31, 2026.

The contract extension amendment will allow for the following:

- Continuation of all current services provided by the County at existing reimbursement rates; and
- Opportunity for CalOptima Health staff to coordinate with the County to transition to the new provider contract template approved by the Board at its August 6, 2026, meeting.

Due the complexity of the County's current contract, the extension will allow ample time to begin discussions with the appropriate teams to work toward implementing a new contract before or by December 2031.

Fiscal Impact

The recommended action to extend the Coordination and Provision of Public Health Care Services Contract with the County is a budgeted item with no additional fiscal impact anticipated. Management will include expenses related to the contract extension for the period on or after July 1, 2027, in future operating budgets.

Rationale for Recommendation

The recommended action will allow for continuation of member benefits under the Coordination and Provision of Public Health Services contract.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Action](#)
2. [Draft Amendment to Extend the Coordination and Provision of Public Health Services Contract with the County of Orange](#)

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
August 6, 2026	Approve Actions Related to New Provider Services Contract Template and Associated Exhibits	Not Applicable	Not Applicable
December 7, 2023	Approve Amendment to Extend CalOptima Health Public Health Services Contract with the County of Orange and Add Provisions for New CalAIM Services	December 31, 2026	Not Applicable

Attachment to the October 1, 2026, Board of Directors Meeting – Agenda Item #17

CONTRACTED / IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Orange County Health Care Agency	405 W 5 th Street	Santa Ana	CA	92701

**AMENDMENT [X]
TO THE
COORDINATION AND PROVISION OF PUBLIC HEALTH CARE SERVICES CONTRACT**

This Amendment to the Coordination and Provision of Public Health Care Services Contract (“Amendment [X]”) is entered into by and between the Orange County Health Authority, a public agency, dba CalOptima Health (“CalOptima”), and the County of Orange, a political subdivision of the State of California, through its division the Orange County Health Care Agency (“County”), and shall become effective on the first day of the first month following execution of this Amendment (“Effective Date”), with respect to the following:

RECITALS

- A. CalOptima and County entered into a Coordination and Provision of Public Health Care Services Contract (“Contract”) effective June 1, 2013, to set forth the manner in which their respective services shall be coordinated and outline the specific services for which County will be reimbursed by CalOptima as required by CalOptima’s contract with the Department of Health Care Services (“DHCS”).
- B. CalOptima and County desire to amend the Contract on the terms and conditions set forth herein

NOW, THEREFORE, the parties agree as follows:

- 1. Section 8.1 “Term” shall be deleted in its entirety and replaced with the following:

“8.1” Term. The term of this contract shall be from January 1, 2027 through December 31, 2031.

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 18 shall have the same meanings ascribed to them in the Contract.

If there is any conflict or inconsistency between this Amendment 18 and the Contract, the provisions of this Amendment 18 shall control and govern. Except as otherwise amended by this Amendment 18, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment 18 Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment 18. This Amendment 18 is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[signature page follows]

IN WITNESS WHEREOF, CalOptima and County have executed this Amendment [X].

FOR COUNTY:
CALOPTIMA:

FOR

Signature

Signature

Print Name

Print Name

Title

Title

Date

Date

Approved as to form:
County Counsel
County of Orange, California

By: _____

Date: _____

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

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

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Action

Approve the adoption of the Funding Priorities Framework for purposes of CalOptima Health's grantmaking activities.

Background/Discussion

CalOptima Health serves hundreds of thousands of children, families, seniors, and individuals with complex health and social needs throughout Orange County as a Medi-Cal health plan. But coverage alone does not guarantee health. Health is shaped not only in clinics and hospitals, but in neighborhoods, homes, schools, and workplaces. Housing stability, food security, behavioral health support, transportation access, cultural responsiveness, and trusted community partnerships all influence whether individuals can access care and achieve lasting well-being.

As a public entity and Orange County's Medi-Cal managed care plan, CalOptima Health is entrusted with stewarding public resources to strengthen both healthcare delivery and the broader ecosystem that supports its members. CalOptima Health's grantmaking over the past five years reflects that responsibility.

A Funding Priorities Framework establishes a clear, disciplined, and transparent approach to how CalOptima Health contributes to reinvestment and philanthropic resources to improve measurable outcomes and build healthier communities across Orange County.

CalOptima Health has identified alignment between its key stakeholder groups, its Strategic Plan, the Department of Health Care Services' Community Reinvestment requirements, and local community health indicators and improvement plans. This alignment is the foundation for CalOptima Health's three funding priorities, also known as its ABCs of strategic investment:

- Advancing Coverage and High-Quality Care
- Building Healthy Communities,
- Cultivating Member Health and Well-being.

The complete Funding Priorities Framework can be found in Attachment 1 and has been reviewed by the CalOptima Health Board of Directors Budget and Policy Assessment Ad Hoc committee.

Together, these three focus areas create a comprehensive strategy: strengthening systems, supporting communities, and empowering members. Each reinforces the others, advancing equity and building a more resilient health ecosystem across Orange County.

In practice, to ensure these priorities are successfully integrated into future funding opportunities, CalOptima Health staff will review grant proposals against these core areas and establish clear guidelines and evaluation metrics, CalOptima Health staff aim to identify and support initiatives that best address members' needs. By collaborating with community partners, CalOptima Health will significantly amplify its impact and foster innovative solutions tailored to local health challenges.

For any specific funding opportunities listed in the Funding Priorities Framework, staff will return to the Board of Directors (Board) to request approval to design scopes of work and allocate funds to execute the opportunity. Furthermore, CalOptima Health will continue to manage grantmaking activities in alignment with CalOptima Health Policy AA.1400: Grant Management and will continue to report back to the Board on the outcomes and impact of such activities.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

CalOptima Health staff recommends that the Board adopt the Funding Priorities Framework to guide the strategic and effective distribution of community investments and direct the impact of those grant awards.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. [CalOptima Health's Funding Priorities Framework](#)



Funding Priorities Framework

**Strengthening Systems, Supporting Communities,
Empowering Members**

August 2026

Our Commitment

CalOptima Health was created to ensure that Orange County residents who rely on Medi-Cal have access to high-quality, coordinated healthcare.

Today, we serve hundreds of thousands of children, families, seniors, and individuals with complex health and social needs.

But coverage alone does not guarantee health.

Health is shaped not only in clinics and hospitals, but in neighborhoods, homes, schools, and workplaces. Housing stability, food security, behavioral health support, transportation access, cultural responsiveness, and trusted community partnerships all influence whether individuals can access care and achieve lasting well-being.

As Orange County's public Medi-Cal managed care plan, CalOptima Health is entrusted with stewarding public resources to strengthen both healthcare delivery and the broader ecosystem that supports our members.

Our grantmaking reflects that responsibility.

This Funding Priorities Framework establishes a clear, disciplined, and transparent approach to how CalOptima Health invests reinvestment and philanthropic resources to improve measurable outcomes and build healthier communities across Orange County.

Role as a Community-Based Strategic Grantmaker

CalOptima Health's grantmaking is grounded in partnership, stewardship, and accountability.

Community-based organizations, safety-net providers, local governments, and cross-sector collaboratives are often closest to the lived experiences of our members. They bring trust, cultural competence, and innovation that are essential to meaningful health improvement.

Our role is not to replace community leadership — but to strengthen and align it.

As a public health plan, we are uniquely positioned to:

- Identify service gaps through data and quality metrics
- Understand systemic barriers affecting Medi-Cal members
- Align investments with statewide transformation efforts
- Bridge healthcare delivery and community conditions

Our investments are intentional and outcome-oriented. They are designed to:

- Improve measurable member health outcomes
- Strengthening healthcare and community infrastructure
- Reduce disparities
- Support long-term sustainability
- Complement — not duplicate — covered Medi-Cal services

We focus on building capacity, supporting innovation, and closing gaps that traditional reimbursement structures alone cannot address.

Through alignment with our Strategic Plan, Department of Health Care Services (DHCS) Community Reinvestment requirements, and local community health priorities, CalOptima Health ensures that its funding decisions remain mission-driven, transparent, equitable, and accountable.

Why This Work Matters Now

Orange County faces complex and evolving challenges that disproportionately affect Medi-Cal members:

- Workforce shortages in primary and behavioral healthcare
- Rising housing instability and homelessness
- Behavioral health and substance use crises
- Persistent disparities across race, ethnicity, language, disability, and geography
- Increasing complexity of member needs

At the same time, Medi-Cal transformation efforts are advancing whole-person, community-based care models.

This moment calls for coordinated action and thoughtful investment.

CalOptima Health's funding priorities are designed to meet this moment — strengthening systems, stabilizing communities, and empowering members in ways that create both immediate and lasting impact.

The ABCs of Strategic Investment

CalOptima Health has identified alignment between its key stakeholder groups, its Strategic Plan, the Department of Health Care Services' Community Reinvestment requirements, and local community health indicators and improvement plans. This alignment is the foundation for our three funding priorities, our ABCs of strategic investment:

- ❖ **A**dvancing Coverage and High-Quality Care
- ❖ **B**uilding Healthy Communities
- ❖ **C**ultivating Member Health and Well-being

Together, these three focus areas create a comprehensive strategy: strengthening systems, supporting communities, and empowering members. Each reinforces the others, advancing equity and building a more resilient health ecosystem across Orange County

Priority A. Advancing Coverage and High-Quality Care

FOCUS: Provider Level Investment

This priority aims to enhance the healthcare delivery system by strengthening the medical and behavioral health workforce, ensuring culturally responsive care, and implementing innovative care models. The initiative involves recruiting, training, and retaining skilled professionals, promoting cultural competence among providers, and integrating medical and behavioral health services. Additionally, it uses technologies such as telehealth and electronic health records to improve access to and coordination of care, ensuring high-quality, comprehensive, and personalized services for its members.

Access to coverage must translate into meaningful access to care.

Orange County continues to face shortages in primary care, specialty care, and behavioral health providers serving Medi-Cal members. Without sustained investment in workforce development, cultural responsiveness, and care coordination, disparities in access and outcomes persist.

As part of this priority, efforts are made to recruit, train, and retain healthcare professionals equipped with the skills and knowledge to address the diverse health needs of the community. By fostering a robust workforce, CalOptima Health ensures that its members receive competent

and compassionate care from professionals who are up to date on the latest advancements in the field and actively seek to incorporate cultural understanding into the care process.

In addition to workforce development and culturally responsive care, CalOptima Health is focused on implementing innovative care models that address the unique needs of its members. These models are designed to provide comprehensive, coordinated, and patient-centered care, which is essential for managing chronic conditions and improving overall health outcomes.

Strategic Objectives

- Expand workforce pipelines and retention
- Increase behavioral health capacity
- Promote culturally and linguistically responsive care
- Improve provider quality performance and integration
- Support innovation in care delivery models

Illustrative Investment Areas

- Medical and behavioral health workforce development
- Recruitment and retention initiatives
- Provider quality collaboratives tied to measurable outcomes
- Technology-enabled access and care coordination
- Enrollment and retention support initiatives
- Provider education on benefits and community resources

Expected Impact

- Improved quality performance measures
- Increased provider participation in Medi-Cal
- Reduced appointment wait times
- Expanded behavioral health access
- Improved member experience

Priority B. Building Healthy Communities

FOCUS: Community Level Investment

This priority focuses upstream on addressing members' health-related social needs. Recognizing that health extends beyond medical care, this priority emphasizes the importance of safe housing, nutritious food, education, adequate income, and more. Through this priority, we will build environments that support the overall well-being of Orange County residents, including systems-change work to address access to essential services, programs that promote social cohesion, and efforts to improve living conditions for our members.

Health begins where people live.

For many Medi-Cal members, unmet social needs — including housing instability and limited access to community supports — drive health instability and avoidable healthcare utilization.

This priority is focused upstream on addressing members' health-related social needs.

Recognizing that health extends beyond medical care, this priority emphasizes the importance of safe housing, nutritious food, education, adequate income, and more. Through this priority, we will build environments that support the overall well-being of Orange County residents, including systems-change work to address access to essential services, programs that promote social cohesion, and efforts to improve living conditions for our members.

To effectively build healthy communities, CalOptima Health invests in and advocates for systemic changes that address these fundamental needs. By collaborating with community organizations, local governments, and other stakeholders, CalOptima Health seeks to create environments that support the overall well-being of its members.

Furthermore, CalOptima Health is committed to integrating social determinants of health into its care models. This approach ensures that healthcare providers are aware of and responsive to the broader context of their patients' lives, ultimately leading to more holistic and effective care. By addressing both medical and social needs, CalOptima Health aims to reduce health disparities and improve overall health outcomes for its members.

Strategic Objectives

- Increase housing stability
- Address health-related social needs
- Strengthening community-based infrastructure

- Promote cross-sector collaboration
- Advance structural equity

Illustrative Investment Areas

- Housing capital and supportive housing initiatives
- Health-related social needs infrastructure
- Community-based health literacy programs
- Systems alignment efforts
- Capacity-building for community-based organizations

Expected Impact

- Increased housing stability
- Reduced emergency department utilization
- Improved care adherence
- Stronger coordination between healthcare and social service systems

Priority C. Cultivating Member Health and Well-being

FOCUS: Member Level Investment

This priority focuses on driving care outcomes and cultivating the health and well-being of CalOptima Health's members. Members are met "where they are," are supported in understanding and accessing their benefits, and can achieve their highest level of health. One key driver is reducing disparities in health outcomes, particularly for vulnerable populations. This priority emphasizes behavioral health, care integration from the member's perspective, and preventive services.

Members must be empowered to navigate care and engage in prevention.

Many Medi-Cal members face barriers related to language, digital access, stigma, transportation, and system complexity. Targeted support is necessary to ensure equitable access and measurable improvement.

Behavioral health is a critical component of overall well-being, and CalOptima Health is dedicated to expanding access to mental health and substance use services. By integrating these services with primary care, members receive comprehensive support that addresses both physical and mental health needs. This coordinated approach ensures care is seamless and centered on members' experiences, leading to better health outcomes and higher satisfaction.

Preventive services are also a cornerstone of cultivating member health. By focusing on early detection and intervention, CalOptima Health aims to prevent the onset of cancers and chronic diseases and manage existing conditions more effectively. This includes promoting regular screenings, vaccinations, and health education initiatives that empower members to take an active role in their health.

Ultimately, the goal of this priority is to create an equitable healthcare system where all members have access to high-quality, timely, and appropriate care. By reducing barriers to care and addressing the unique needs of vulnerable populations, CalOptima Health strives to improve its members' health and well-being and to foster a healthier community overall.

Strategic Objectives

- Expand behavioral health access
- Promote preventive care and early intervention
- Strengthen care navigation and outreach
- Reduce disparities among high-risk populations
- Improve health and digital literacy

Illustrative Investment Areas

- Behavioral health access initiatives
- Care navigation programs
- Street medicine and outreach
- Prevention and screening campaigns
- Member-focused health and digital literacy

Expected Impact

- Improved preventive care metrics
- Reduced avoidable hospitalizations
- Increased behavioral health utilization
- Measurable reductions in health disparities

Cross-Cutting Commitments

Across all funding priorities, CalOptima Health is guided by:

Health Equity: Prioritizing communities and populations experiencing documented disparities.

Collaboration: Encouraging partnerships across healthcare, community organizations, and local government.

Data and Measurable Outcomes: Requiring clear goals, performance metrics, and evaluation plans.

Sustainability: Favoring scalable models and durable infrastructure investments.

Transparency: Communicating clearly about funding priorities, selection criteria, and impact.

Accountability and Stewardship

Disciplined stewardship of public resources is central to our approach.

To ensure these priorities are successfully integrated into future funding opportunities, CalOptima Health staff will review and align grant proposals with these core areas. By establishing clear guidelines and evaluation metrics, we aim to identify and support initiatives that best address our members' needs. Collaborative efforts with community partners will also be pivotal in amplifying our impact and fostering innovative solutions tailored to local health challenges.

Furthermore, CalOptima Health commits to transparently reporting on the outcomes and impact of our grantmaking activities. Regular assessments and public reports will provide insights into how our investments are driving progress in preventive services, reducing disparities, and improving access to essential healthcare resources. This ongoing evaluation will enable us to refine our strategies and ensure that our funding continues to contribute to a healthier, more equitable community.

Together, through dedicated efforts and strategic funding, we can make significant strides in enhancing the well-being of all CalOptima Health members and ensure our investments remain responsive, responsible and effective.

Investing In Health, Together

Healthier members and stronger communities are inseparable.

By strengthening provider capacity, stabilizing community conditions, and empowering members, CalOptima Health advances a more equitable and resilient healthcare system for Orange County.

Through partnership, stewardship, and measurable accountability, we will continue investing in initiatives that create lasting impact — improving outcomes today while building a healthier future for generations to come.

Operationalizing Priorities Through Funding Opportunities

CalOptima Health is committed to translating our priorities into actionable funding initiatives throughout this fiscal year and beyond. For FY2027, we have established planned funding opportunities that align with our core focus areas of transparency, accountability, and stewardship. These programs are designed to support projects that enhance preventive care, reduce health disparities, and strengthen community partnerships.

FY2027

	Advancing Coverage and High-Quality Care	Building Health Communities	Cultivating Member Health and Well-being
Planned	- Provider Rate Increases - Workforce Development Physician Recruitment Incentive Program - Quality Incentive Grant Program	- Housing and Homelessness Incentive Program Round 7 - City Health Improvement Grants Round 1 - CalOptima Health's Community Resource Center - Street Medicine Support Center	- Cancer Screening Grant Program Round 2 - Street Medicine Expansion- Coastal Collaborative - Whatever It Takes Program
Proposed	Community Enrollers Academy	Behavioral Health Wellness Spaces (TBD)	Work and Community Engagement Navigation Program

Looking ahead, we are actively proposing new funding opportunities for FY2028 and FY2029. Our goal is to expand support for innovative solutions and broaden the reach of our grantmaking efforts to address evolving member needs. By continually refining our guidelines and evaluation metrics, CalOptima Health will ensure that investments remain responsive to both current and future health challenges, fostering sustained progress across Orange County.

FY2028

	Advancing Coverage and High-Quality Care	Building Health Communities	Cultivating Member Health and Well-being
Proposed	▪ Provider Rate Increases ▪ Community Enrollers Round 4 ▪ Quality Incentive Grant Program ▪ Dyadic Care Expansion ▪ Collaborative Care Behavioral Health Integration Pilot	▪ City Health Improvement Grants Round 2 ▪ Street Medicine Support Center ▪ Behavioral Health Wellness Spaces	▪ Employment Navigation Round 2 ▪ Whatever It Takes Program ▪ Street Medicine Expansion

FY2029

	Advancing Coverage and High-Quality Care	Building Health Communities	Cultivating Member Health and Well-being
Proposed	▪ Provider Rate Increases ▪ Quality Incentive Grant Program	▪ PACE Expansion- Irvine	▪ Member Health NOFO TBD ▪ Whatever It Takes Program

Currently Funded Projects Connecting to the MPHNA

Portfolio/Grantee	Portfolio Value	Total Number of Grants	Timeframe	Behavioral Health		Access to Care		Health Related Social Needs			Culture and Linguistics	
				Behavioral Health Care Navigation	BH Integration within Primary Care Setting	Specialty Care Access	Educate Members on Care Pathways	Development of Affordable Housing	Referral to Social Services	New Workforce, Employment, Job Training	Outreach on Cultural and Linguistic Services	Promote Culturally Safe Conversations
Behavioral Health Grants	\$ 9,571,250	3	2023-2028	X								
Street Medicine	\$ 23,460,083	7	2023-2027	X	X	X			X			
Housing and Homeless Incentive Program - Round 1	\$ 36,631,423	35	2023-2028					X	X			
Housing and Homeless Incentive Program - Round 2	\$ 52,300,000	15	2024-2029					X				
Housing and Homeless Incentive Program - Round 3	\$ 25,780,000	14	2025-2035					X	X			
Housing and Homeless Incentive Program - Round 4	\$ 2,700,000	6	2025-2030					X	X			
Housing and Homeless Incentive Program - Round 5	\$ 10,000,000	6	2026-2035					X				
Community Enrollers Round 1	\$ 4,073,325	12	2024-2026				X					
Community Enrollers Round 2	\$ 3,499,160	7	2026-2028				X					

Portfolio/Grantee	Portfolio Value	Total Number of Grants	Timeframe	Behavioral Health		Access to Care		Health Related Social Needs			Culture and Linguistics	
				Behavioral Health Care Navigation	BH Integration within Primary Care Setting	Specialty Care Access	Educate Members on Care Pathways	Development of Affordable Housing	Referral to Social Services	New Workforce, Employment, Job Training	Outreach on Cultural and Linguistic Services	Promote Culturally Safe Conversations
Community Enrollers Round 3	\$ 3,552,548	7	2026-2028				X					
Community Supports Capacity Building 2023	\$ 2,200,000	22	2024-2026				X		X			
ECM Academy Cohort 3	\$ 1,200,000	12	2025-2026				X					
Justice Involved Learning Network	\$ 1,000,000	5	2025-2026				X		X			
Cancer Screening Program	\$ 16,417,044	15	2025-2027			X						
Quality Improvement Grant Program	\$ 4,633,957	37	2025-2026		X		X					
Quality Improvement Grant Program	\$ 1,752,482	8	2026-2027		X		X					
Workforce Development Round 1	\$ 24,596,300	7	2023-2028							X		
Workforce Development Round 2	\$ 5,140,772	6	2024-2029							X		
CSUF - MSW Stipend Program	\$ 5,000,000	1	2023-2028							X		
Coalition of OC Community Health Centers - PHVBC	\$ 50,000,000	1	2022-2027				X					
Food Bank Grants	\$ 4,200,000	4	2025-2027						X			

CalOptima Health

Community Investment Funding Priorities

Summary Sheet

A dvancing Coverage and High-Quality Care	B uilding Health Communities	C ultivating Member Health and Wellbeing
FOCUS: Provider Level Investment	FOCUS: Community Level Investment	FOCUS: Member Level Investment
This priority <i>aims to enhance the healthcare delivery system</i> by strengthening the medical and behavioral health workforce, ensuring culturally responsive care, and implementing innovative care models. The initiative involves recruiting, training, and retaining skilled professionals, promoting culturally competent providers, and integrating medical and behavioral health services. Additionally, it utilizes technology to improve access and coordination of care for our members.	This priority <i>focuses upstream on addressing members' health-related social needs</i>. This priority emphasizes the importance of safe housing, nutritious food, education, adequate income, and other basic needs. Through this priority, we will build environments that support the overall well-being of Orange County residents, including system-change work to address access to essential services, programs that promote social cohesion, and efforts to improve living conditions for our members.	This priority <i>focuses on driving care outcomes and cultivating the health and well-being of CalOptima Health's members</i>. Members are met “where they are,” are supported in understanding and accessing their benefits, and can achieve their highest level of health. One key driver is reducing disparities in health outcomes, particularly for vulnerable populations. This priority emphasizes behavioral health, care integration from the member's perspective, and preventive services.
- Workforce development - Enrollment and retention support (HR1) - BH workforce - Culturally responsive care - Provider quality initiatives - Benefit/resource literacy (covered/uncovered)	- Housing/capital - SDOH/Health-related social needs - Health literacy and education - Systems change - Nutritional support - Basic Income	- BH services (access) - Prevention services - Reduce disparities for vulnerable populations - Care navigation - Street medicine - Healthcare/digital literacy (member benefits)

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

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

Contacts

Veronica Carpenter, Chief Administrative Officer, (657) 900-1161

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

Recommended Action

1. Authorize 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. Authorize 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.
3. Allocate 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.

Background

Recent federal and state legislative changes to Medi-Cal eligibility requirements will result in dramatic impacts to Medi-Cal managed care plans and county agencies. Changes include the future implementation of work requirements and more frequent redetermination for certain adult members. This will require a broad, multifaceted outreach and education campaign throughout Orange County to help members retain their Medi-Cal coverage. As a part of CalOptima Health's outreach strategy, on October 2, 2025, the Board of Directors (Board) appropriated a total of \$19.0 million in aggregate from the existing \$38.0 million Community Reinvestment Program commitment to fund the expanded Medi-Cal Eligibility Outreach Strategy through December 31, 2028.

From this funding, CalOptima Health awarded \$7.1 million to 14 organizations to conduct community enrollment work for two years. Half of these grantees began work in March 2026 and the other half began in July 2026. While this strategy provides useful support to individuals enrolling or re-enrolling in Medi-Cal, staff know there will be additional challenges in the coming year when new and additional eligibility requirements go into effect. These changes will create additional demand for support in both

the enrollment process and in navigating the new requirements, thus requiring new strategies and increased community capacity.

Discussion

CalOptima Health staff recommend expanding the Medi-Cal Eligibility Outreach Strategy to include two additional programs: (i) a Community Enrollers Academy and (ii) a pilot Work and Community Engagement Requirement (WCER) Navigation Service Program.

Community Enrollers Academy

While grants have supported several organizations with a history of doing community enrollment work, CalOptima Health's community partners have indicated that enrollment work should also be conducted by a wider variety of social service organizations, who have reached into populations not currently connected to enrollment providers. These social service organizations do not have extensive enrollment experience; therefore, CalOptima Health staff proposes hosting a Community Enrollers Academy, to train and certify these organizations to conduct the work.

As a part of this effort, CalOptima Health will sole-source a contract in the amount up to \$100,000 to Community Health Initiative of Orange County (CHIOC), the lead agency in Orange County with a mission to train community enrollers, to facilitate and host the Community Enrollers Academy. The three-month Community Enrollers Academy will ensure selected participants will have the training and support needed to effectively conduct community enrollment work. Furthermore, once selected participants complete the Community Enrollers Academy, they will receive a \$200,000 grant award to fund their community enrollment work for two years.

CalOptima Health staff will design a scope of work and release a competitive Notice of Funding Opportunity (NOFO) to solicit proposals from organizations with little-to-no experience doing community enrollment work, but with documented connection to CalOptima Health members. Staff anticipates launching this Community Enrollers Academy NOFO in December 2026, with the Community Enrollers Academy commencing in April 2027. Through the NOFO process, staff will select up to ten (10) organizations to participate and will bring recommended grantees from the NOFO back to the Board for approval in February 2027.

Staff requests a total allocation of up to \$2.1 million to fund the one-year contract with CHIOC and the grant awards to ten (10) organizations participating in the Community Enrollers Academy.

WCER Navigation Service Program

To address the community's need for support in understanding and meeting the work and community engagement requirement, CalOptima Health staff will design a NOFO to solicit proposals from organizations. The selected organizations will participate in a pilot program that will provide navigation support to individuals applying for and re-enrolling in Medi-Cal.

Beginning in January 2027, to become or remain eligible for Medi-Cal, individuals that are not exempt will need to meet a work and community engagement requirement either through reporting monthly income or spending time on qualified activities such as employment, volunteerism, education, and training. To support members in understanding, meeting, and documenting their resolution of this

requirement, CalOptima Health will provide funding to selected organizations to pilot a WCER Navigation Service Program to individuals seeking to meet this requirement.

WCER Navigation Service Program assistance will include, at a minimum, accepting referrals from external partners, conducting assessments of how individuals can meet this requirement, creating plans to support individuals in meeting the requirement, providing supportive services to help individuals execute their plans (*e.g.*, resume submission, application to community college, etc.), and obtaining documentation for individuals to use in their Medi-Cal application. CalOptima Health staff will design a full scope of work and release a competitive NOFO to solicit proposals from organizations to conduct this work. Staff anticipates launching the WCER Navigation Service Program NOFO in February 2027, with grant-funded activities beginning in June 2027. Through the NOFO process, staff will select up to four (4) organizations to participate and will bring recommended grantees from the NOFO back to the Board for approval in May 2027.

Staff requests an allocation of up to \$4.0 million to fund annual grant awards of \$500,000 each to four entities over a two-year period for the pilot WCER Navigation Service Program.

Per CalOptima Health Policy AA.1400: Grants Management, staff will return to the Board to provide updates on the status of these grant programs at future meetings.

Fiscal Impact

A previous Board action on October 2, 2025, appropriated \$12.0 million from the Community Reinvestment Program commitment for future Board-approved Medi-Cal Eligibility Outreach Strategy activities. This funding will be sufficient to cover the estimated cost of up to \$6.1 million for the contract with CHIOC, the Community Enrollers Academy NOFO, and the pilot WCER Navigation Service Program NOFO. After Board approval of the recommended actions, the remaining unallocated balance for future Board-approved Medi-Cal Eligibility Outreach Strategy activities is \$5.9 million.

Rationale for Recommendation

Funding these community grants will aid CalOptima Health in efforts to conduct robust regional outreach and education campaigns, provide and promote countywide enrollment activities, and increase access to care for CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. [Entities Covered by this Action](#)

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 7, 2023	Authorize Adult Expansion Outreach Strategy to Make Eligible Adults Ages 26 Through 49 Aware of the Opportunity to Apply for Full-Scope Medi-Cal Regardless of Immigration Status	-	\$5,000,000
August 1, 2024	Approve Actions Related to the Community Enrollers for Medi-Cal Notice of Funding Opportunity	-	\$1,993,486
October 3, 2024	Approve Actions Related to the Community Enrollers for Medi-Cal Notice of Funding Opportunity	-	\$2,579,819
October 2, 2025	Approve Actions Related to the Medi-Cal Outreach Strategy	-	\$5,000,000
February 5, 2026	Approve Actions Related to the Medi-Cal Eligibility Outreach Strategy Community Engagement and Enrollers Notice of Funding Opportunity		\$4,500,000

Attachment to the October 1, 2026, Board of Directors Meeting – Agenda Item #19

CONTRACTED / IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Community Health Initiative of Orange County	1505 E. 17th Street Suite 108	Santa Ana	CA	92705

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

20. Approve New CalOptima Health Provider Contract Termination Policy EE.1142

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Approve new CalOptima Health Policy EE.1142: CalOptima Health Provider Contract Termination, effective October 1, 2026.

Background and Discussion

CalOptima Health's provider contracts contain provisions governing the contract termination process. The provisions define the circumstances under which either CalOptima Health or the provider may initiate the termination of the contract. The provisions are mutually agreed upon by both CalOptima Health and the provider at the time of contract execution.

To support the contractual provisions and provide clarification of the contract termination process, staff developed the new CalOptima Health Policy EE.1142: Provider Contract Termination that outlines the procedures by which CalOptima Health or a provider may terminate a provider contract.

Policy EE.1142 summarizes the grounds for termination in alignment with CalOptima Health's standard provider contract provisions. The policy also details the required steps that both CalOptima Health and the provider must follow to effectuate a contract termination. Key components of the policy include:

- Categories of provider contract terminations and the circumstances under which each may be initiated;
- Documentation requirements to support proper processing;
- Notification requirements describing how a provider is informed of a termination;
- Obligations of a provider upon contract termination;
- Compliance with applicable regulatory requirements;
- Examples of termination reasons and the associated termination type; and
- Provider appeal rights.

Staff requests CalOptima Board of Director (Board) approval of the new CalOptima Health Policy EE.1142, to establish a dedicated policy that clearly defines the process for terminating provider contracts.

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 2026-27 Operating Budget.

Rationale for Recommendation

CalOptima Health staff recommends that the CalOptima Health Board approve and adopt the new policy to support transparency of the important process of initiating a provider contract termination.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. [CalOptima Health Policy EE.1142: CalOptima Health Provider Contract Termination](#)



Policy: EE.1142
Title: **CalOptima Health Provider Contract Termination**
Department: Contracting
Section: Not Applicable

CEO Approval: /s/

Effective Date: 10/01/2026
Revised Date:

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

I. PURPOSE

This policy establishes the process and requirements by which CalOptima Health may terminate a Provider's contract. CalOptima Health will administer all Provider terminations in accordance with the termination provisions outlined in the Provider's contract and applicable CalOptima Health policies, including this Policy, thus ensuring compliance with state and federal laws and regulatory obligations.

II. POLICY

A. Grounds for Termination: CalOptima Health may terminate a Provider's participation in CalOptima Health's network under any of the following circumstances, as specified in the Provider's contract:

1. Immediate Termination: Termination is initiated when, among other things, continuation of the contract could immediately harm a member's health, safety or welfare; when a Provider's required licenses are suspended or revoked; or when a federal or state agency issues sanctions or disciplinary action against the Provider. Other instances where Immediate Termination of a provider contract may apply are outlined in Table 1.
2. Termination for Cause (Default/Breach): Termination is initiated when CalOptima Health determines that the Provider has failed to meet contractual obligations, including but not limited to failure to perform required duties, non-compliance with CalOptima Health's policies and/or compliance requirements, or material breach of contract that is not timely cured. CalOptima Health shall give prior written notice of its intent to terminate with a thirty (30) day cure period if the termination is curable, in the sole discretion of CalOptima Health. Other instances where Termination for Cause of a Provider contract may apply are outlined in Table 1.
3. Termination without Cause: Termination is initiated by either CalOptima Health or the Provider within the time period allowed under the contract – typically, but no less than ninety (90) days' prior written notice. CalOptima Health reserves the right, at its sole discretion, to terminate a Provider's contract for business reasons not identified above, as permitted under the contract.
 - a. Examples of reasons for termination without cause are outlined in Table 1.

- 1 B. Committee Review for Other Termination Request: If a request to terminate a Provider contract,
2 whether initiated by the Provider or by CalOptima Health, does not clearly fall under any of the
3 termination categories identified in Section A of this policy, the request shall be referred to
4 CalOptima Health Provider Network Access and Adequacy Committee for review in consultation
5 with legal counsel.
6
7 C. Termination Requirements: A Provider's contract may be terminated in accordance with all
8 applicable CalOptima Health policies and the requirements established by the Department of Health
9 Care Services (DHCS), Centers for Medicare and Medicaid, and California Department of Managed
10 Care (DMHC) including, but not limited to, All Plan Letter (APL) 21-003: Medi-Cal Network
11 Provider and Subcontractor Terminations. CalOptima Health shall ensure that all contract
12 terminations adhere to statutory and regulatory obligations, regulator guidance, contractual
13 provisions, and internal procedural standards.
14
15 D. Provider Appeals Rights
16
17 a. If the Provider disagrees with a contract termination, the Provider may exercise appeal rights in
18 accordance with CalOptima Health Policies CC.1202: CalOptima Health Covered Provider
19 Complaint, HH.1101: CalOptima Health Provider Complaint, MA.9006: Contracted Provider
20 Complaint Process, and MA.9009: Non-Contracted Provider Complaint Process.
21
22 b. If the contract termination is related to an adverse action for medical cause or reason described
23 in CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, the Provider may
24 exercise the fair hearing rights described within that policy.
25

26 III. PROCEDURE

27 A. Termination Categories and Key Processes

- 28
29
30 1. Immediate Termination: An Immediate Termination is defined as a termination that becomes
31 effective on the same day the action is initiated through CalOptima Health's notice to Provider
32 or on the following calendar day. See Table 1 for examples of reasons for Immediate
33 Termination.
34
35 a. Documentation Requirements: CalOptima Health staff who identify a contract termination
36 event ("Reporting Department") shall collect all supporting documentation substantiating
37 the basis for the Immediate Termination, including evidence related to licensure action,
38 Member safety concerns, and/or other pertinent information. The Reporting Department
39 must provide to the Contracting Department supporting documentation and copies of any
40 communications issued to the Provider regarding the Immediate Termination.
41
42 b. Notice of Immediate Termination to Provider
43
44 i. The Contracting Department shall ensure that every Immediate Termination letter
45 identifies the reason for the Immediate Termination.
46
47 ii. The Contracting Department shall issue the formal contract termination notification the
48 same business day, or following business day, from the date the Contracting
49 Department received the termination request.
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51 iii. The Contract Department shall send the contract termination notification via registered
52 or certified U.S. mail, or through another delivery method that provides verifiable proof
53 of delivery.

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2. Termination for Cause (Default/Breach): Termination for Cause is a termination initiated due to a Provider's material breach, default, or failure to meet contractual obligations (i.e., breach) (other than the obligations tied to Immediate Termination). Termination for Cause requires issuance of a thirty (30)-day written notice, which may include an opportunity for the Provider to cure when CalOptima Health deems the breach is curable. If CalOptima Health identifies such breach is curable, CalOptima Health shall allow the Provider (30) days to remedy. If such breach is not remedied within the prescribed cure period, the contract shall terminate at the conclusion of the thirty (30)-day notice period. If CalOptima Health determines that the breach is non-curable, the Termination for Cause shall be effective at the end of the notice period without an opportunity to cure.
- a. Documentation Requirements: The Reporting Department shall collect all supporting documentation substantiating the basis for the Termination for Cause, including evidence of Medi-Cal enrollment status, credentialing deficiencies, Provider outreach attempts, or other pertinent information. The Reporting Department must provide supporting documentation and copies of all communications issued to the Provider regarding the Termination for Cause.
- b. Notice of Termination for Cause to Provider
- i. The Contracting Department shall ensure that each termination letter describes the breach and specifies whether the termination is curable, including identification of any applicable cure period, the conditions required for the Provider to remedy the deficiency, and date the deficiency must be completed.
- ii. The Contracting Department shall issue a contract termination only after the Provider fails to remedy the identified deficiencies (if curable) and the cure period has ended.
- iii. The Contracting Department shall issue the formal contract termination notification within three (3) business days from the date the Termination for Cause request is received.
- iv. The Contract Department shall send the contract termination notification via registered or certified U.S. mail, or through another delivery method that provides verifiable proof of delivery.
3. Termination without Cause: Either CalOptima Health or the Provider may initiate Termination without Cause. The termination typically requires ninety (90) days' prior written notice, but in any event, must be consistent with the notice provisions described in the Provider's contract. Neither CalOptima Health nor a Provider is required to provide a reason for Termination without Cause. CalOptima Health may request a reason from the Provider for internal documentation purposes.
- a. Documentation Requirements (Provider): Provider must be submitted any Provider-initiated Termination without Cause in writing and include sufficient identifying information to ensure accurate processing of the termination. Required information includes:
- i. Provider name
- ii. Tax identification number (TIN)
- iii. National Provider Identifier (NPI)

iv. Service Location Address(es)

v. Termination Reason (if applicable); and

vi. Provider Signature or authorized representative signature and title

b. Documentation Requirements: The Reporting Department shall collect all supporting documentation substantiating the basis for the Termination without Cause and the reason for the termination. The Reporting Department must provide supporting documentation and copies of all communications issued to the Provider regarding the termination to the Contracting Department.

c. Notice for Termination without Cause to Provider

i. The Contracting Department shall ensure that every Termination without Cause termination letter identifies the effective date of the termination.

ii. The Contracting Department shall issue the formal contract termination notification within five (5) business days from the date the termination request is received.

iii. The Contracting Department shall send the contract termination notification via registered or certified U.S. mail, or through another delivery method that provides verifiable proof of delivery.

B. Obligations Upon Termination/Continuity of Care

1. For Terminations without Cause, the Provider shall continue to furnish authorized services to Members who retain eligibility and are under the Provider's care at the time of termination. Such services shall be provided until the course of treatment is completed, unless CalOptima Health, in its sole discretion, makes reasonable and medically appropriate arrangements for the assumption of those services.

2. The Provider shall continue to render services to hospitalized Members, or coordinate such services with contracted hospitalists, in accordance with accepted medical standards and practices. These services shall be continued until the earlier of the Member's discharge, or alternate coverage or care arrangements made by CalOptima Health.

3. Continuity of Care requirements shall be in accordance with CalOptima Health Policies CC.1501: Continuity of Care During Health Network or Provider Termination, GG.1304: Continuity of Care During Health Network or Provider Termination, and MA.6021: Continuity of Care for Members Involuntarily Transitioning Between Providers and Practitioners.

C. Contract Reinstatement

1. CalOptima Health is not obligated to reinstate a Provider contract following termination. Reinstatement may occur only when the Provider satisfies all reinstatement requirements.

a. To be considered for reinstatement, the Provider must meet all credentialing requirements in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organization Providers.

D. Table 1 – Examples of Termination Reasons*

Termination Type	Examples
Immediate Termination	• Member's Health at risk • License suspended/revoked • Sanctions/Disciplinary actions imposed • Insolvency or file for bankruptcy • Required due to changes in federal/state laws • Failure to comply with Participation Status (as defined in the contract) requirements • Committed fraud, waste, or abuse (FWA) or allowed FWA in connection with Provider's contract • CalOptima determines Provider's facility, equipment, or personnel are insufficient • Violation of law or receipt of an indictment • Failure to satisfy terms of a corrective action plan • Termination or non-renewal of government contract or applicable waivers • Termination required by regulator • Death of Provider • Failure to maintain required insurance policies
Termination for Cause	• Failure to perform contracted duties (other than those tied to Immediate Termination) • Committing acts that discriminate against members • Failure to provide covered services in scope of contract • Engage in prohibited marketing activities • Failure to comply with CalOptima's compliance program • Loss of Medi-Cal enrollment • Credentialing deficiencies • CalOptima Health is unable to reach/locate the provider • Materially breached any other contractual obligations
Termination without Cause	• CalOptima Health-initiated termination • Provider-initiated termination

*This is not an all-inclusive list, and the contract and CalOptima Health policies may contain additional grounds for termination.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Policy CC.1202: CalOptima Health Covered Provider Complaint
- B. CalOptima Health Policy CC.1501: Continuity of Care During Health Network or Provider Termination
- C. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
- D. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organization Providers
- E. CalOptima Health Policy GG.1304: Continuity of Care During Health Network or Provider Termination
- F. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint.
- G. CalOptima Health Policy MA.6021: Continuity of Care for Members Involuntarily Transitioning Between Providers and Practitioners

- H. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
I. CalOptima Health Policy MA.9009: Non-Contracted Provider Complaint Process
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network
Provider and Subcontractor Termination (Supersedes APL 16-001)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective		EE.1142	CalOptima Health Provider Contract Termination	Covered California Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Continuity of Care	Services provided to a Member rendered by a terminated Provider with whom the Member has a pre-existing provider relationship.
Member	<u>Covered California</u>: 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. <u>Medi-Cal</u>: 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. <u>OneCare</u>: An individual enrolled in the CalOptima Health OneCare program. <u>PACE</u>: Any Eligible Medi-Cal Beneficiary who has enrolled in CalOptima Health PACE's plan in accordance with the provisions of California Code of Regulations title 22, section 53420.
Provider	<u>Covered California</u>: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. <u>Medi-Cal</u>: 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. <u>OneCare</u>: 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.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2026

Regular Meeting of the CalOptima Health Board of Directors

Discussion Item

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

Contacts

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

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

Recommended Action

Authorize, 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:

- a.\$300,000 for architectural, engineering, and consultant services; and
- b.\$16,610,000 for tenant improvement and base building construction costs.

Background

In October 2013, CalOptima Health began operating a Program of All-Inclusive Care for the Elderly (PACE) to provide coordinated and integrated health care services to frail elders, helping them continue to live independently in the community. CalOptima Health's PACE Center is located at 13300 Garden Grove Boulevard in Garden Grove, California, and has served members for over 12 years.

At the February 5, 2026, meeting, the CalOptima Health Board of Directors (Board) authorized the submission of two nonbinding Letters of Intent for the purchase of real property for a future PACE site. In addition, the Board authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter negotiations and select one real property for a PACE site and recommend a final purchase price and sale agreement for the Board's approval.

At the March 5, 2026, meeting, the Board authorized the CEO, with the assistance of Legal Counsel, to enter into negotiations for real property located at 17838 Gillette Avenue, Irvine, California (the Subject Property) not to exceed \$30.0 million, and to authorize submission of the final PACE expansion application to the Centers for Medicare & Medicaid Services by March 27, 2026, including the Subject Property.

A Purchase and Sale Agreement was executed on June 11, 2026, and escrow was officially opened. An initial earnest money deposit of \$425,000 was made to the seller on June 15, 2026. CalOptima Health engaged consultants to perform building inspections and the due diligence period concluded on

September 7, 2026. Inspections were satisfactorily completed and Legal Counsel released contingencies for all due diligence items on September 7, 2026. The second earnest money deposit of \$425,000 was transmitted to the seller on September 28, 2026, and the estimated closing date for the purchase of the Subject Property is October 16, 2026.

Discussion

The Subject Property will become CalOptima Health's second PACE site in Orange County. The two-story, 58,619-square-foot building is well-situated to expand access to comprehensive care for frail seniors and support the organization's long-term strategic goals.

Due to the timing of this property acquisition, design and construction-related costs were not budgeted in the current fiscal year. To ensure the timely development of the new PACE center, staff seek the Board's approval for an initial funding allocation of \$16.91 million. This amount reflects the building's condition, size, and market-average construction cost. This allocation will be used towards architectural design, engineering soft costs, permits, and baseline construction activities. Approval of the recommended action will enable staff to initiate design work immediately upon close of escrow, secure required consultant support, initiate the construction procurement process, and maintain the planned timeline for launching the new PACE center for services to CalOptima Health PACE members. The following table lists the estimated costs associated with construction of the new PACE site:

Estimated Costs by Category	Est. Cost	Cost Per Square Foot
1. Architectural, Engineering and Consultant Services	\$300,000	\$5.12
2. Base Building Improvement (Hard and Soft Demolition, Roof Coating, ADA Path, and Other General Contractor Services)	\$900,000	\$15.35
3. Tenant Improvements (Based on building condition and size)	\$15,710,000	\$268.00
Total:	\$16,910,000	\$288.47

Staff will procure these services in accordance with Board-approved Policy GA.5002: Purchasing. If the actual funding needed differs from the initial estimate, staff will return to the Board with separate requests for additional authority. Staff will also provide the Board with regular updates on the development progress of CalOptima Health's second PACE site in Irvine to ensure transparency and continued oversight.

Fiscal Impact

The recommended action is unbudgeted. An appropriation not to exceed \$16.91 million in undesignated reserves will fund these actions.

Rationale for Recommendation

The recommendation will provide CalOptima Health with a long-term presence to provide access to PACE services in south Orange County.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Action](#)
2. [Purchase and Sale Agreement between CalOptima Health and MIM Intersect Owner, LLC](#)
3. [First Amendment to Purchase and Sale Agreement between CalOptima Health and MIM Intersect Owner, LLC](#)
4. [Second Amendment to Purchase and Sale Agreement between CalOptima Health and MIM Intersect Owner, LLC](#)

Attachment to the October 1, 2026, Board of Directors Meeting – Agenda Item #21

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MIM Intersect Owner, LLC, a Delaware limited liability company	601 South Figueroa Street #2900	Los Angeles	CA	90017

17838 GILLETTE AVENUE, IRVINE, CA 92614

**PURCHASE AND
SALE AGREEMENT**

BETWEEN

MIM INTERSECT OWNER, LLC,
a Delaware limited liability company

AS SELLER,

AND

ORANGE COUNTY HEALTH AUTHORITY,
a public agency,
dba CalOptima Health

AS PURCHASER

As of 6/11/2026

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EXHIBITS

- A DESCRIPTION OF LAND .
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- C LIST OF OPERATING AGREEMENTS
- D LIST OF ENVIRONMENTAL REPORTS
- E FORM OF DEED
- F FORM OF BILL OF SALE
- G FORM OF ASSIGNMENT OF CONTRACTS
- H FORM OF FIRPTA CERTIFICATE
- I LIST OF SPECIFIED LITIGATION
- J LIST OF VIOLATION NOTICES

PURCHASE AND SALE AGREEMENT

This PURCHASE AND SALE AGREEMENT (this "Agreement") is made as of 6/11, 2026 (the "Effective Date"), by and between **MIM INTERSECT OWNER, LLC**, a Delaware limited liability company ("Seller") and **ORANGE COUNTY HEALTH AUTHORITY**, a public agency, dba CalOptima Health ("Purchaser").

ARTICLE I

PURCHASE AND SALE

Section 1.1 Agreement of Purchase and Sale. Subject to the terms and conditions hereinafter set forth, Seller agrees to sell, assign and convey to Purchaser, and Purchaser agrees to purchase and assume from Seller, the following:

(a) that certain tract or parcel of land situated in Orange County, California, more particularly described in Exhibit A attached hereto and made a part hereof, together with all of Seller's rights, privileges, easements and appurtenances pertaining to such property, including any right, title and interest of Seller in and to the tenements, hereditaments, adjacent streets, alleys or rights-of-way, including, without limitation, all mineral, oil and gas and other subsurface rights, water rights, approvals (governmental or otherwise), and wastewater discharge capacity entitlements relating to the Property (as defined below), commonly known as 17838 Gillette Avenue, Irvine, CA 92614 (the property described in clause (a) of this Section 1.1 being herein referred to collectively as the "Land");

(b) any and all of Seller's right, title and interest in and to the buildings, structures, fixtures and other improvements affixed to or located on the Land, excluding fixtures owned by tenants (the property described in clause (b) of this Section 1.1 being herein referred to collectively as the "Improvements");

(c) any and all of Seller's right, title and interest in and to all tangible personal property located upon the Land or within the Improvements, including, without limitation, any and all appliances, furniture, furnishings, machinery, equipment, carpeting, draperies and curtains, tools and supplies, and other items of personal property owned by Seller (excluding cash and any software), located on and used exclusively in connection with the operation of the Land and the Improvements, which personal property includes without limitation the personal property listed on Exhibit B attached hereto (the property described in clause (c) of this Section 1.1 being herein referred to collectively as the "Personal Property");

(d) any and all of Seller's right, title and interest in and to the leases, licenses and occupancy agreements and amendments thereof covering all or any portion of the Real Property (as defined in Section 1.2 (Property Defined) hereof), to the extent they are in effect on the date of the Closing (as such term is defined in Section 4.1 (Time and Place) hereof) (the property described in clause (d) of this Section 1.1 being herein referred to collectively as the "Leases"), together with all rents, including, but not limited to, fixed monthly rent, additional rent, percentage rent, escalation rent (which includes any tenant's proportionate share of building operation and maintenance costs and expenses as provided for under the applicable Lease, to the extent the same

exceeds any base year specified in such Lease), reimbursements of real estate taxes and operating expenses, including, but not limited to, all administrative changes, utility charges, storage rentals and other charges payable to Seller or its successor by any tenant under the applicable Lease or from other occupants or users of the Property, and other sums due thereunder (collectively, the “Rents”) and any and all security deposits in Seller’s possession in connection therewith (the “Security Deposits”); and

(e) any and all of Seller’s right, title and interest in and to (i) all assignable contracts and agreements (collectively, the “Operating Agreements”) listed and described on Exhibit C attached hereto and made a part hereof, relating to the upkeep, repair, maintenance or operation of solely the Land, Improvements or Personal Property, which Seller does not elect to terminate with respect to the Property prior to Closing, and (ii) all assignable existing warranties and guaranties (express or implied) issued to Seller solely in connection with the Improvements or the Personal Property, and (iii) all assignable existing permits, licenses, approvals and authorizations issued by any governmental authority solely in connection with the Property, and (iv) all plans and specifications, surveys, studies, reports, and maps solely in connection with the Property to the extent in Seller’s actual possession (the property described in clause (e) of this Section 1.1 being sometimes herein referred to collectively as the “Intangibles”).

Section 1.2 Property Defined. The Land and the Improvements are hereinafter sometimes referred to collectively as the “Real Property.” The Land, the Improvements, the Personal Property, the Leases and the Intangibles are hereinafter sometimes referred to collectively as the “Property.” Notwithstanding anything to the contrary contained herein, the Property will not include any rights to the use of, and Purchaser shall not have the right to use, the name “Intersect” or “Intersect Irvine”.

Section 1.3 Purchase Price. Seller is to sell and Purchaser is to purchase the Property for the amount of TWENTY-NINE MILLION THREE HUNDRED NINE THOUSAND FIVE HUNDRED AND 00/100 DOLLARS (\$29,309,500.00) (the “Purchase Price”).

Section 1.4 Payment of Purchase Price. The Purchase Price, as increased or decreased by prorations and adjustments as herein provided, shall be payable in full at Closing in cash by wire transfer of immediately available funds to the Escrow Agent (as defined below).

Section 1.5 Deposit.

(a) Within two (2) Business Days (as herein defined) after the execution and delivery of this Agreement, Purchaser shall deposit with Chicago Title Insurance Company (the “Escrow Agent”), having its office at 26415 Carl Boyer Drive, Santa Clarita, CA 91350, Attention: Maggie Watson, SVP (watsonma@ctt.com), the sum of Four Hundred Twenty-Five Thousand and 00/100 Dollars (\$425,000.00) (the “Initial Deposit”) in immediately available federal funds, by federal wire transfer. Within two (2) Business Days after the expiration of the Inspection Period (as hereinafter defined), provided that Purchaser has delivered the Inspection Period Approval Notice (as hereinafter defined), Purchaser shall deposit with Escrow Agent an additional Four Hundred Twenty-Five Thousand and 00/100 Dollars (\$425,000.00) (the “Additional Deposit” and together with the Initial Deposit and the GAP Extension Deposit (if made), the “Deposit”) with the Escrow Agent, which shall be applied to the Purchase Price at Closing. The parties hereby acknowledge

that One Hundred Dollars (\$100.00) (the “Independent Contract Consideration”) of the Initial Deposit has been bargained for and agreed to as consideration for Purchaser’s right to inspect the Real Property and perform its due diligence as provided herein, and for Seller’s execution and delivery of this Agreement. Notwithstanding any contrary provision of this Agreement, (i) upon execution of this Agreement, the Independent Contract Consideration is fully earned by Seller and nonrefundable in all events, and shall be immediately released by Escrow Agent to Seller; and (ii) every reference in this Agreement to the Deposit being refundable or being returned to Purchaser shall exclude the Independent Contract Consideration. The Escrow Agent shall hold the Deposit in an interest-bearing account reasonably acceptable to Seller and Purchaser, in accordance with the terms and conditions of this Agreement. All interest earned on the Deposit shall become a part of the Deposit and shall be deemed income of Purchaser, and Purchaser shall be responsible for the payment of all costs and fees imposed on the Deposit account. The Deposit shall be distributed in accordance with the terms of this Agreement. The failure of Purchaser to timely deliver the Initial Deposit and/or the Additional Deposit hereunder shall be a material default, and shall entitle Seller, at Seller’s sole option, to terminate this Agreement immediately after two (2) Business Days’ written notice to Purchaser to cure. At Closing, the Deposit shall be paid to Seller and credited against the Purchase Price. A “Business Day” shall mean every day other than Saturdays, Sundays, all days observed by the federal or California government as legal holidays and all days on which commercial banks in California are required by law to be closed. Any reference in this Agreement to a “day” or a number of “days” (other than references to a “Business Day” or “Business Days”) shall mean a calendar day or calendar days. In the event any deadline specified herein falls on a day which is not a Business Day, then the deadline shall be extended to the end of the next following regular Business Day.

(b) Except for the Independent Contract Consideration, the Deposit remains refundable to Purchaser prior to the expiration of the Inspection Period. After the expiration of the Inspection Period, the Deposit shall be non-refundable to Purchaser except in connection with the termination of this Agreement pursuant to Section 3.4(d) (Governmental Approvals), Section 4.6 (Conditions Precedent to Obligations of Purchaser), Section 5.4(b) (Covenants of Seller), Section 6.2 (Default by Seller), or Section 7.2 (Major Damage) of this Agreement.

Section 1.6 Escrow Agent.

(a) Escrow Agent shall hold and dispose of the Deposit in accordance with the terms of this Agreement. Seller and Purchaser shall execute and deliver to Escrow Agent any additional or supplementary instructions as may be necessary or convenient to implement the terms of this Agreement and close the transactions contemplated hereby, provided such instructions are consistent with and do not modify this Agreement. Seller and Purchaser agree that the duties of the Escrow Agent hereunder are purely ministerial in nature and shall be expressly limited to the safekeeping and disposition of the Deposit in accordance with this Agreement. Escrow Agent shall incur no liability in connection with the safekeeping or disposition of the Deposit for any reason other than Escrow Agent’s willful misconduct or gross negligence. In the event that Escrow Agent shall be in doubt as to its duties or obligations with regard to the Deposit, or in the event that Escrow Agent receives conflicting instructions from Purchaser and Seller with respect to the Deposit, Escrow Agent shall not disburse the Deposit and shall, at its option, continue to hold the Deposit until both Purchaser and Seller agree as to its disposition or until a final judgment is

entered by a court of competent jurisdiction directing its disposition, or Escrow Agent shall interplead the Deposit in accordance with the laws of the state in which the Property is located.

(b) Escrow Agent shall not be responsible for any interest on the Deposit except as is actually earned, or for the loss of any interest resulting from the withdrawal of the Deposit prior to the date interest is posted thereon or for any loss caused by the failure, suspension, bankruptcy or dissolution of the institution in which the Deposit is deposited.

(c) Escrow Agent shall execute this Agreement solely for the purpose of being bound by the provisions of Sections 1.5 (Deposit) and 1.6 (Escrow Agent) hereof.

(d) Escrow Agent is designated the “real estate reporting person” for purposes of Section 6045 of title 26 of the United States Code and Treasury Regulation 1.6045-4 and any instructions or settlement statement prepared by Escrow Agent shall so provide. Upon the consummation of the transaction contemplated by this Agreement, Escrow Agent shall file Form 1099 information return and send the statement to Seller as required under the aforementioned statute and regulation.

(e) Upon the Closing (as defined below), Escrow Agent shall promptly undertake all of the following: (i) disburse all funds deposited with Escrow Agent by Purchaser as follows: (A) deduct all items chargeable to the account of Seller; (B) disburse the balance of the Purchase Price and any additional amounts owed to Seller under this Agreement to Seller by wire transfer in accordance with instructions received from Seller; and (C) disburse the remaining balance of the funds, if any, to Purchaser, (ii) cause the Deed and any other documents which the parties hereto may mutually direct to be recorded (in the order provided herein) in the Official Records of the County in which the Property is located and obtain conformed copies thereof for distribution to Purchaser and Seller, (iii) direct the Title Company (as defined below) to issue the Title Policy (as defined below) to Purchaser, and (iv) deliver a conformed copy of the recorded Deed and an original of all other Closing documents to each party.

ARTICLE II

TITLE AND SURVEY

Section 2.1 Title Inspection Period. During the period beginning upon the Effective Date and ending at 5:00 p.m. (local time at the Property) on the date that is ten (10) Business Days prior to the expiration of the Inspection Period (hereinafter referred to as the “Title Inspection Period”), Purchaser shall have the right to review (a) a current preliminary title report on the Real Property, accompanied by copies of all documents referred to in the report, which shall be obtained by Purchaser promptly after the Effective Date (with a copy of the preliminary title report to be simultaneously furnished to Seller); (b) copies of the most recent property tax bills for the Property; (c) a survey of the Real Property prepared by a licensed surveyor or engineer hired by Purchaser (the “Survey”); and (d) a copy of Seller’s title insurance policy and/or survey for the Real Property (collectively, the “Existing Title Policy and Survey”), if in Seller’s actual possession. For purposes of this Agreement, “promptly” shall mean no later than five (5) Business Days.

Section 2.2 Title Examination. Purchaser shall notify Seller in writing (the “Title Notice”) prior to the expiration of the Title Inspection Period which exceptions to title (including survey matters), if any, will not be accepted by Purchaser. If Purchaser fails to notify Seller in writing of its disapproval of any exceptions to title by the expiration of the Title Inspection Period, Purchaser shall be conclusively deemed to have approved the condition of title to the Real Property. If Purchaser notifies Seller in writing that Purchaser objects to any exceptions to title prior to the expiration of the Title Inspection Period, Seller shall have five (5) Business Days after receipt of the Title Notice to notify Purchaser (a) that Seller will remove such objectionable exceptions from title on or before the Closing; provided that Seller may extend the Closing for such period as shall be required to effect such cure, but not beyond thirty (30) days; or (b) that Seller elects not to cause such exceptions to be removed. The procurement by Seller of a commitment for the issuance of the Title Policy (as defined in Section 2.5 (Conveyance of Title) hereof) or an endorsement thereto (in form and substance reasonably acceptable to Purchaser) insuring Purchaser against any title exception which was disapproved pursuant to this Section 2.2 shall be deemed a cure by Seller of such disapproval. If Seller does not deliver a response to Purchaser’s Title Notice, then Seller will be deemed to not have agreed to have any of the objectionable items set forth in the Title Notice removed. If Seller gives Purchaser notice under clause (b) above or fails to respond to a Title Notice within said five (5) Business Day period, Purchaser shall have until the earlier of (i) the date that is five (5) Business Days therefrom or (ii) the expiration of the Inspection Period in which to notify Seller that Purchaser will nevertheless proceed with the purchase and take title to the Property subject to such exceptions, or that Purchaser will terminate this Agreement. If this Agreement is terminated pursuant to the foregoing provisions of this paragraph, then neither party shall have any further rights or obligations hereunder (except for any indemnity obligations of either party pursuant to the other provisions of this Agreement and other obligations of either party that expressly survive the termination of this Agreement), the Deposit shall be returned to Purchaser and each party shall bear its own costs incurred hereunder. If Purchaser shall fail to notify Seller of its election prior to the earlier of (x) the expiration of said five (5)-Business-Day period or (y) the expiration of the Inspection Period, Purchaser shall be deemed to have elected to proceed with the purchase and take title to the Property subject to such exceptions.

Section 2.3 Pre-Closing “Gap” Title Defects. Purchaser may, at or prior to Closing, notify Seller in writing (the “Gap Notice”) of any objections to title (a) raised by the Title Company (as defined in Section 2.5 (Conveyance of Title) hereof) between the expiration of the Title Inspection Period and the Closing and (b) not disclosed by the Title Company or otherwise known to Purchaser prior to the expiration of the Title Inspection Period; provided that Purchaser must notify Seller of such objection to title prior to the earlier of (i) the date that is two (2) Business Days after Purchaser is made aware of the existence of such exception or (ii) the then-scheduled date of the Closing (the “Gap Notice Deadline”). If Purchaser sends a Gap Notice to Seller, Purchaser and Seller shall have the same rights and obligations with respect to such notice as apply to a Title Notice under Section 2.2 (Title Examination) hereof. If Purchaser fails to deliver a Gap Notice by the Gap Notice Deadline, then Purchaser shall be deemed to have waived its right to object to the new title matter and the same shall constitute a Permitted Exception (as defined below). Notwithstanding the foregoing or any contrary provision of this Agreement, if a new title matter included in a Gap Notice does not have a material adverse effect upon the value of the

Property, such title matter shall be deemed a Permitted Exception and Purchaser shall have no right to terminate this Agreement hereunder in connection with such matter.

Section 2.4 Permitted Exceptions. The Property shall be conveyed subject to the following matters, which are hereinafter referred to as the “Permitted Exceptions”:

(a) those matters that either are not objected to in writing within the time periods provided in Sections 2.2 (Title Examination) or 2.3 (Pre-Closing “Gap” Title Defects) hereof, or if objected to in writing by Purchaser, are those which Seller has elected not to remove or cure, or has been unable to remove or cure, and subject to which Purchaser has elected or is deemed to have elected to accept the conveyance of the Property; however, that in no event shall Permitted Exceptions include (i) any monetary liens, deeds of trust, or other encumbrances securing indebtedness voluntarily created or assumed by Seller, or (ii) any matters created by, through or under Seller after the Effective Date in violation of this Agreement without Purchaser’s prior written consent;

(b) all Operating Agreements;

(c) the rights of tenants under the Leases, to the extent any changes in terms after the Effective Date of such Leases have been approved by Purchaser in writing;

(d) the lien of all ad valorem real estate taxes and assessments not yet due and payable as of the date of Closing, subject to adjustment as herein provided;

(e) local, state and federal laws, ordinances or governmental regulations, including but not limited to, building and zoning laws, ordinances and regulations, now or hereafter in effect relating to the Property; and

(f) items shown on the Survey and not objected to by Purchaser or waived or deemed waived by Purchaser in accordance with Section 2.2 (Title Examination) hereof (or all matters that would have been disclosed by an updated ALTA survey as of the expiration of the Title Inspection Period if no updated survey is sought by Purchaser).

Section 2.5 Conveyance of Title. At Closing, Seller shall convey and transfer to Purchaser fee simple title to the Land and Improvements, by execution and delivery of the Deed (as defined in Section 4.2(a) (Seller’s Obligations at Closing) hereof). Evidence of delivery of such title shall be the issuance by Chicago Title Insurance Company (the “Title Company”) of an CLTA Standard Owner’s Policy of Title Insurance (the “Title Policy”) covering the Real Property, in the full amount of the Purchase Price, subject only to the Permitted Exceptions.

ARTICLE III

REVIEW OF PROPERTY

Section 3.1 Right of Inspection. During the period beginning upon the Effective Date and ending at 5:00 p.m. (local time at the Property) on the date that is sixty (60) days after the Effective Date (hereinafter referred to as the “Inspection Period”), Purchaser and its directors,

officers, affiliates, agents, employees, consultants, attorneys, inspectors, appraisers, engineers and contractors, representatives and advisors (collectively, "Purchaser's Representatives") shall have the right to make a physical inspection of the Real Property, including an inspection of the environmental condition thereof pursuant to the terms and conditions of this Agreement, and the Diligence Documents (as hereinafter defined). Within five (5) Business Days after the Effective Date, Seller shall deliver or make available via an electronic data room to Purchaser the following documents that are then in Seller's or Seller's property manager's actual possession or control (collectively, the "Diligence Documents"): (a) the Existing Title Policy and Survey, (b) the current property tax bill; (c) any soils, seismic, environmental (including Phase I environmental reports), engineering or similar reports relating to the Property; (d) any agreements with adjoining landowners affecting the Property; (e) building plans and specifications; (f) copies of the Lease, if any; (g) historical operating expense information relating to the Property; (h) insurance policies relating to the Property; (i) copies of the Operating Agreements, if any; and (j) any documents relating to existing entitlements affecting the Property, including conditional use permits or land use restrictions, in each case, to the extent in Seller's or Seller's property manager's actual possession or control, but excluding Seller's partnership or corporate records, internal memoranda, financial projections, budgets, materials relating to Seller's sale or financing negotiations, internal valuations of the Property, appraisals, accounting and tax records and similar proprietary, confidential or privileged information, including, but not limited to, attorney-client work product (collectively, the "Confidential Documents"). Seller will provide the Diligence Documents solely as a convenience to Purchaser. Seller makes no representation or warranty of any kind or nature, either oral or written, directly or indirectly, express, implied, statutory or otherwise, with respect to the Diligence Documents. The Diligence Documents shall not be deemed or construed in any way to be a representation or warranty of Seller of any kind or nature either oral or written, directly or indirectly, express, implied, statutory or otherwise. Seller shall have no obligation or liability whatsoever with respect to, or in any way arising out of, the Diligence Documents.

Purchaser understands and agrees that any on-site inspections of the Property shall occur at reasonable times agreed upon by Seller and Purchaser after reasonable prior written notice to Seller and shall be conducted so as not to interfere unreasonably with the use of the Property by Seller or its tenants. In conducting the inspection of the Property and its due diligence review, Purchaser shall at all times comply with all applicable laws and regulations of all applicable governmental authorities. Seller reserves the right to have a representative present during any such inspections. If Purchaser desires to do any environmental testing (including without limitation, a Phase II environmental study or any air, soil, mold or water sampling) or invasive testing at the Property, (including without limitation testing which would otherwise damage or disturb any portion of the Property), Purchaser shall do so only after notifying Seller and obtaining Seller's prior written consent thereto, which consent may be subject to any terms and conditions imposed by Seller in its sole and absolute discretion (for any reason or no reason), including without limitation, providing Seller with evidence of insurance in form and substance satisfactory to Seller and the prompt restoration of the Property to its condition prior to any such inspections or tests, at Purchaser's sole cost and expense. In no event shall Purchaser provide any governmental entity or agency with information concerning the environmental condition of the Property without obtaining Seller's prior written consent thereto, which Seller agrees to provide in the event that Purchaser is required by applicable law to provide such information to a governmental entity or agency. At Seller's option, Purchaser will furnish to Seller copies of any reports received by

Purchaser relating to any inspections of the Property, at no cost to Seller. Purchaser shall not have the right to contact or communicate with tenants or counterparties to the Operating Agreements without Seller's prior written approval (which may be by email), which such consent by Seller shall not be unreasonably withheld, conditioned, or delayed. Seller reserves the right to have a representative present during any such contact or communications and shall be copied on all written correspondence (including emails). All due diligence activities or communications shall be subject to the terms and provisions of the Leases. Seller may from time to time establish additional reasonable rules of conduct in connection with Purchaser's entry onto the Property. Purchaser shall be liable and responsible for Purchaser's Representatives, and all references in this Section 3 to obligations, liabilities, restrictions or other covenants pertaining to Purchaser shall also pertain to Purchaser's Representatives. Purchaser agrees to protect, indemnify, defend and hold Seller and its direct and indirect shareholders, officers, directors, partners, principals, members, and its and their employees, agents and contractors, and any successors or assigns of the foregoing (collectively with Seller, the "Seller Related Parties") harmless from and against any claims, liabilities, liens, losses, costs, expenses (including, but not limited to, reasonable attorneys' fees, court costs and disbursements), damages or injuries incurred by any Seller Related Parties arising out of or resulting from entry onto the Property or the activities on, including the inspection of, the Property by Purchaser or Purchaser's Representatives, and notwithstanding anything to the contrary in this Agreement, such obligation to indemnify and hold harmless Seller shall survive Closing or any termination of this Agreement; provided, however, such indemnity shall not extend to protect Seller from any liabilities caused by the gross negligence or willful misconduct of Seller or any Seller Related Parties, nor shall the foregoing apply to the mere discovery of any pre-existing condition at the Property or any portion thereof, except to the extent Purchaser and/or Purchaser's agents, employees, contractors or consultants exacerbate such pre-existing condition, in which event Purchaser shall only be liable to the extent of such exacerbation (but not the underlying condition).

Section 3.2 Environmental Reports. PURCHASER ACKNOWLEDGES AND AGREES THAT (1) PURCHASER HAS RECEIVED COPIES OF THE ENVIRONMENTAL REPORTS LISTED ON EXHIBIT D ATTACHED HERETO, (2) IF SELLER DELIVERS ANY ADDITIONAL ENVIRONMENTAL REPORTS TO PURCHASER, PURCHASER WILL ACKNOWLEDGE IN WRITING THAT IT HAS RECEIVED SUCH REPORTS PROMPTLY UPON RECEIPT THEREOF, AND (3) ANY ENVIRONMENTAL REPORTS DELIVERED OR TO BE DELIVERED BY SELLER OR ITS AGENTS OR CONSULTANTS TO PURCHASER ARE BEING MADE AVAILABLE SOLELY AS AN ACCOMMODATION TO PURCHASER AND MAY NOT BE RELIED UPON BY PURCHASER IN CONNECTION WITH THE PURCHASE OF THE PROPERTY. SELLER MAKES NO REPRESENTATION OR WARRANTY OF ANY KIND OR NATURE, DIRECTLY OR INDIRECTLY, EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, WITH RESPECT TO THE ENVIRONMENTAL REPORTS LISTED ON EXHIBIT D AND PROVIDED TO PURCHASER. PURCHASER AGREES THAT SELLER SHALL HAVE NO LIABILITY OR OBLIGATION WHATSOEVER FOR ANY INACCURACY IN OR OMISSION FROM ANY ENVIRONMENTAL REPORT. PURCHASER HAS CONDUCTED, OR WILL CONDUCT PRIOR TO THE EXPIRATION OF THE INSPECTION PERIOD, ITS OWN INVESTIGATION OF THE ENVIRONMENTAL CONDITION OF THE PROPERTY TO THE EXTENT PURCHASER DEEMS SUCH AN INVESTIGATION TO BE NECESSARY OR APPROPRIATE.

Section 3.3 Inspection Period Right of Termination. If for any reason whatsoever Purchaser determines that the Property or any aspect thereof is unsuitable for Purchaser's acquisition, Purchaser shall have the right to terminate this Agreement by giving written notice thereof (the "Inspection Period Termination Notice") to Seller prior to the expiration of the Inspection Period, and if Purchaser gives such notice of termination within the Inspection Period, this Agreement shall terminate. If this Agreement is terminated pursuant to the foregoing provisions of this paragraph, then neither party shall have any further rights or obligations hereunder (except for any indemnity obligations of either party pursuant to the other provisions of this Agreement and other obligations of either party that expressly survive the termination of this Agreement), the Initial Deposit shall be returned to Purchaser and each party shall bear its own costs incurred hereunder. If Purchaser fails to timely deliver the Inspection Period Termination Notice, then Purchaser shall be deemed to have approved all aspects of the Property (except as expressly set forth in Section 2.3 (Pre-Closing "Gap" Title Defects)), and Purchaser shall no longer have any right to terminate this Agreement pursuant to this Section 3, excepting the termination provisions set forth in Section 3.4 below.

Section 3.4 Governmental Approvals.

(a) After the Effective Date, Purchaser shall promptly submit applications for the Governmental Approvals and shall use commercially reasonable efforts to pursue the Governmental Approvals with the objective of obtaining the same during the period beginning on the Effective Date and ending at 5:00 p.m. (local time at the Property) on the date that is six (6) months following the Effective Date (the "Governmental Approvals Period"). For purposes hereof, the "Governmental Approvals" shall mean, collectively, the following: (a) all approvals required from the City of Irvine for Purchaser's intended use of the Property as medical services and administrative offices, including any Administrative Use Permit, Conditional Use Permit, modification of any existing Conditional Use Permit, or other similar entitlement required for such use; and (b) written confirmation from the Centers for Medicare & Medicaid Services ("CMS") that Purchaser's Program of All-Inclusive Care for the Elderly application applicable to the Property has been approved or is reasonably expected to be approved (the "CMS Approval"), as determined by Purchaser in its sole discretion, exercised in good faith.

(b) Seller shall reasonably cooperate at Purchaser's requests with respect to the Governmental Approvals, provided that such requests shall not result in any material cost or expense to Seller. Purchaser shall not file any applications relating to the Governmental Approvals without providing at least five (5) Business Days' prior written notice to Seller and obtaining Seller's prior approval thereof, which approval shall not be unreasonably withheld, conditioned or delayed. Purchaser's design and use of the Property shall be subject to the approval of Seller taking into account the adjacent properties owned by Seller, which approval shall not be unreasonably withheld, conditioned or delayed.

(c) Purchaser shall not voluntarily withdraw any application for Governmental Approvals without Seller's prior written consent, which shall not be unreasonably withheld, conditioned or delayed; provided, however that Purchaser may withdraw any such application in its sole discretion if Purchaser determines in good faith that such application is not achievable on commercially reasonable terms or conditions. Purchaser shall be solely responsible for all costs

and expenses incurred in connection with pursuing the Governmental Approvals. Purchaser shall not agree to, accept, or permit any conditions, dedications, easements, restrictions, development agreements, infrastructure obligations, impact fees, or other requirements that would bind the Property, run with the land, or impose any obligation on Seller or the Property without Seller's prior written consent, which shall not be unreasonably withheld, conditioned or delayed. Seller shall not be required to commence litigation, pursue any appeal, or incur any expense in connection with obtaining the Governmental Approvals. Purchaser shall provide to Seller (a) reasonable notice of the scheduling of all meetings with governmental authorities with respect to the Governmental Approvals, and Seller shall have the right to attend all such meetings; and (b) weekly updates of its efforts to obtain the Governmental Approvals.

(d) If the Governmental Approvals have not been obtained by the expiration of the Governmental Approvals Period (as may be extended), then Purchaser shall have the right to terminate this Agreement by delivering written notice thereof (the "Governmental Approvals Termination Notice") to Seller prior to the expiration of the Governmental Approvals Period, in which case, the Deposit (excluding the Independent Contract Consideration) shall be returned to Purchaser, and neither party shall have any further right or obligation under this Agreement except for the Surviving Obligations. Purchaser may also deliver to Purchaser written notice of the waiver of the Governmental Approvals (the "Governmental Approvals Waiver Notice") prior to the expiration of the Governmental Approvals Period. If Purchaser delivers a Governmental Approvals Waiver Notice or fails to deliver the Governmental Approvals Termination Notice to Seller prior to the expiration of the Governmental Approvals Period, then Purchaser shall be deemed to have waived the Governmental Approvals contingency, the Governmental Approvals shall be deemed satisfied for purposes of this Agreement, and Purchaser shall no longer have any right to terminate this Agreement under this Section 3.4. Purchaser shall have the right to extend the Governmental Approvals Period for one (1) additional period of thirty (30) days by delivering written notice to Seller prior to the expiration of the Governmental Approvals Period and depositing into escrow an additional sum of One Hundred Thousand and NO/100 Dollars (\$100,000.00) (the "GAP Extension Deposit"). For avoidance of doubt, Purchaser's waiver or deemed waiver of the Governmental Approvals contingency pursuant to this Section 3.4 shall not constitute a waiver of, or otherwise limit, any separate Purchaser Condition set forth in Section 4.6, including, without limitation, the conditions relating to the Declaration Amendment, the CUP Partial Assignment, or Lender Approval, unless Purchaser expressly waives such condition in writing.

ARTICLE IV

CLOSING

Section 4.1 Time and Place. The consummation of the transaction contemplated hereby (the "Closing") shall be held at the offices of Escrow Agent on the date that is thirty (30) days following the earlier of delivery of the Governmental Approvals Waiver Notice or the expiration of the Governmental Approvals Period (the "Closing Date"). At the Closing, Seller and Purchaser shall perform the obligations set forth in, respectively, Section 4.2 (Seller's Obligations at Closing) and Section 4.3 (Purchaser's Obligations at Closing) hereof, the performance of which obligations shall be concurrent conditions; provided that the Deed shall not be recorded until Seller receives

confirmation that Seller has received the full amount of the Purchase Price, adjusted by prorations as set forth herein. The Closing shall be consummated through an escrow administered by Escrow Agent pursuant to additional escrow instructions that are consistent with this Agreement. The Purchase Price and all documents shall be deposited with the Escrow Agent as escrowee. Time is of the essence as to the Purchaser's obligation to close the transactions contemplated hereunder at Closing.

Section 4.2 Seller's Obligations at Closing. At Closing, Seller shall deliver or caused to be delivered to Escrow Agent the following:

(a) a duly executed and acknowledged grant deed (the "Deed") in the form attached hereto as Exhibit E, conveying the Land and Improvements, subject only to the Permitted Exceptions; the warranty of title in the Deed will be only as to claims made by, through or under Seller and not otherwise;

(b) a duly executed bill of sale (the "Bill of Sale") conveying the Personal Property without warranty of title or use and without warranty, express or implied, as to merchantability and fitness for any purpose and in the form attached hereto as Exhibit F;

(c) a duly executed counterpart to an assignment and assumption agreement (the "Assignment of Contracts") in the form attached hereto as Exhibit G, pursuant to which Seller shall, to the extent assignable, assign to Purchaser, and Purchaser shall assume, Seller's interest in the Operating Agreements and the other Intangibles;

(d) such evidence as the Title Company may reasonably require as to the authority of the person or persons executing documents on behalf of Seller;

(e) a certificate in the form attached hereto as Exhibit H duly executed by Seller stating that Seller is not a "foreign person" as defined in the Federal Foreign Investment in Real Property Tax Act of 1980;

(f) originals (to the extent originals are in Seller's actual possession, or photocopies if originals are not in Seller's actual possession) of the Leases and the Operating Agreements, together with such leasing and property files and records located at the Property or the property manager's office which are material in connection with the continued operation, leasing and maintenance of the Property, but excluding any Confidential Documents; provided, however, Seller may deliver to Purchaser (or make available to Purchaser at the Property) the items referenced in this clause substantially concurrent with the Closing without providing same to Escrow Agent;

(g) such affidavits as may be customarily and reasonably required by the Title Company duly executed by Seller, in a form reasonably acceptable to Seller;

(h) deliver to Purchaser possession and occupancy of the Property, subject to the Permitted Exceptions; provided, however, for the avoidance of doubt, Seller will satisfy this delivery obligation directly to Purchaser outside Escrow;

(i) a duly executed California Form 593 with respect to California withholding requirements; and

(j) a duly executed closing statement acceptable to Seller.

Section 4.3 Purchaser's Obligations at Closing. At Closing, Purchaser shall deliver or cause to be delivered to Escrow Agent the following:

(a) by such time as necessary to permit the Closing to be consummated and Escrow Agent to disburse the Purchase Price to Seller by not later than 1:00 p.m., Pacific time on the Closing Date, the full amount of the Purchase Price (which amount shall include the Deposit), as increased or decreased by prorations and adjustments as herein provided, in immediately available wire transferred funds pursuant to Section 1.4 (Payment of Purchase Price) hereof;

(b) a duly executed counterpart of each of the Assignment of Leases and Assignment of Contracts;

(c) such evidence as the Title Company may reasonably require as to the authority of the person or persons executing documents on behalf of Purchaser;

(d) such affidavits as may be customarily and reasonably required by the Title Company, in a form reasonably acceptable to Purchaser;

(e) a completed and executed Preliminary Change of Ownership Report in the form required by the County and City where the Property is located;

(f) a duly executed closing statement acceptable to Purchaser; and

(g) deliver such additional documents as shall be reasonably required to consummate the transaction contemplated by this Agreement.

Section 4.4 Credits and Prorations.

(a) All income and expenses of the Property shall be apportioned as of 12:01 a.m., on the day of Closing, as if Purchaser were vested with title to the Property during the entire day upon which Closing occurs. Subject to the provisions of this Section 4.4, such prorated items shall include without limitation the following: (i) all collected Rents, if any; (ii) taxes and assessments (including personal property taxes on the Personal Property) levied against the Property, including without limitation, all dues, assessments or other amounts payable by the owner of the Property under any covenants recorded against the Property; (iii) utility charges for which Seller is liable, if any, such charges to be apportioned at Closing on the basis of the most recent meter reading occurring prior to Closing (dated not more than fifteen (15) days prior to Closing) or, if unmetered, on the basis of a current bill for each such utility; (iv) all amounts payable under brokerage agreements and Operating Agreements, pursuant to the terms of this Agreement; and (v) any other operating expenses, income, or other items pertaining to the Property which are customarily prorated between a purchaser and a seller in the county in which the Property is located. No

proration will be made in relation to insurance premiums, and Seller's insurance policies will not be assigned to Purchaser.

(b) Notwithstanding anything contained in Section 4.4(a) hereof:

(i) Any taxes paid at or prior to Closing shall be prorated based upon the amounts actually paid. If taxes and assessments due and payable during the year of Closing have not been paid before Closing, Seller shall be charged at Closing an amount equal to that portion of such taxes and assessments which relates to the period before Closing and Purchaser shall pay the taxes and assessments prior to their becoming delinquent. Any such apportionment made with respect to a tax year for which the tax rate or assessed valuation, or both, have not yet been fixed shall be based upon the tax rate and/or assessed valuation last fixed. To the extent that the actual taxes and assessments for the current year differ from the amount apportioned at Closing, the parties shall make all necessary adjustments by appropriate payments between themselves within thirty (30) days after such amounts are determined following Closing, subject to the provisions of Section 4.4(d) hereof;

(ii) Charges referred to in Section 4.4(a) hereof which are payable by any tenant to a third party shall not be apportioned hereunder, and Purchaser shall accept title subject to any of such charges unpaid and Purchaser shall look solely to the tenant responsible therefor for the payment of the same. If Seller shall have paid any of such charges on behalf of any tenant, and shall not have been reimbursed therefor by the time of Closing, Purchaser shall credit to Seller an amount equal to all such charges so paid by Seller;

(iii) As to utility charges referred to in Section 4.4(a)(iii) hereof, Seller may, upon notice to Purchaser, elect to pay one or more or all of said items accrued to the date hereinabove fixed for apportionment directly to the person or entity entitled thereto, and to the extent Seller so elects, such item shall not be apportioned hereunder, and Seller's obligation to pay such item directly in such case shall survive the Closing or any termination of this Agreement;

(c) Seller may prosecute appeals (if any) of the real property tax assessment for the period prior to the Closing, and may take related action which Seller deems appropriate in connection therewith. Purchaser shall cooperate with Seller in connection with such appeal and collection of a refund of real property taxes paid. Seller owns and holds all right, title and interest in and to such appeal and refund, and all amounts payable in connection therewith shall be paid directly to Seller by the applicable authorities. If such refund or any part thereof is received by Purchaser, Purchaser shall promptly pay such amount to Seller. Any refund received by Seller shall be distributed as follows: first, to reimburse Seller for all costs incurred in connection with the appeal; second, with respect to refunds payable to tenants of the Real Property pursuant to the Leases, to such tenants in accordance with the terms of such Leases; and third, to Seller to the extent such appeal covers the period prior to the Closing, and to Purchaser to the extent such appeal covers the period as of the Closing and thereafter. If and to the extent any such appeal covers the period after the Closing, Purchaser shall have the right to participate in such appeal.

(d) Any and all preliminary estimated Closing proration shall be set forth on a preliminary proration statement to be prepared by Seller and submitted to Purchaser for Purchaser's approval (which approval shall not be unreasonably withheld, delayed or conditioned)

prior to Closing (the "Proration Statement"). The Proration Statement shall be delivered to the Escrow Agent for purposes of Escrow Agent making the proration adjustments at Closing. The proration adjustments from the Proration Statement shall be paid at Closing by Purchaser to Seller (if the preliminary proration results in a net credit to Seller) or by Seller to Purchaser (if the preliminary proration results in a net credit to Purchaser) by increasing or reducing the funds to be delivered by Purchaser in payment of the Purchase Price at the Closing.

(e) Except as otherwise provided herein, any revenue or expense amount which cannot be ascertained with certainty as of Closing shall be prorated on the basis of the parties' reasonable estimates of such amount, and shall be the subject of a final proration forty-five (45) days after Closing, or as soon thereafter as the precise amounts can be ascertained. Purchaser shall promptly notify Seller when it becomes aware that any such estimated amount has been ascertained. Once all revenue and expense amounts have been ascertained, Purchaser shall prepare, and certify as correct, a final proration statement (the "Final Proration Statement") which shall be in a form consistent with the closing statement delivered at Closing and which shall be subject to Seller's approval. Upon Seller's acceptance and approval of the Final Proration Statement submitted by Purchaser, such Final Proration Statement shall be conclusively deemed to be accurate and final, and any payment due to any party as a result of such final proration shall be made in cash or other immediately available funds within thirty (30) days of such approval by Seller.

(f) Subject to the final sentence of Section 4.4(e) hereof, the provisions of this Section 4.4 shall survive Closing.

Section 4.5 Transaction Taxes and Closing Costs.

(a) Seller and Purchaser shall execute, acknowledge and deliver such returns, questionnaires and other documents as shall be required with regard to all applicable real property transaction taxes imposed by applicable federal, state or local law or ordinance;

(b) Seller shall pay the fees of any counsel, advisors, or other professionals representing Seller in connection with this transaction. Seller shall also pay the following costs and expenses:

(i) one-half of the escrow fee, if any, which may be charged by the Escrow Agent or Title Company;

(ii) the fee for the premium for the CLTA standard coverage portion of the Owner's Policy of Title Insurance to be issued to Purchaser by the Title Company at Closing;

(iii) the fees for recording the Deed;

(iv) any transfer tax, sales tax, documentary stamp tax or similar tax which becomes payable by reason of the transfer of the Property from Seller to Purchaser;

(v) the fees for Seller's Broker and Purchaser's Broker; and

(vi) any recording fees or title endorsements to remove any title exceptions that Seller agreed to cure in writing in response to Purchaser's Title Notice under Section 2.2 (Title Examination) or Gap Notice under Section 2.3 (Pre-Closing "Gap" Title Defects).

(c) Purchaser shall pay the fees of any counsel, advisors, or other professionals representing Purchaser in connection with this transaction. Purchaser shall also pay the following costs and expenses:

(i) one-half of the escrow fee, if any, which may be charged by the Escrow Agent or Title Company;

(ii) the fee for the title examination and the Title Commitment and the premium for the extended coverage portion of the ALTA Owner's Policy of Title Insurance to be issued to Purchaser by the Title Company at Closing, and all endorsements thereto (other than the endorsements that Seller is obligated to pay for pursuant to Section 4.5(b)(vi) above);

(iii) the cost of the Survey;

(iv) the fees for recording any documentation to be recorded in connection with the transactions contemplated by this Agreement (other than the Deed);

(v) all costs and expenses incurred in connection with any financing obtained by Purchaser, including, without limitation, loan fees, mortgage recording taxes, financing costs and lender's legal fees.

(d) The Personal Property is included in this sale without charge, except that Purchaser shall pay to Seller the amount of any and all sales or similar taxes payable in connection with the transfer of the Personal Property and Purchaser shall execute and deliver any tax returns required of it in connection therewith;

(e) All costs and expenses incident to this transaction and the closing thereof, and not specifically described above, shall be paid by the party incurring same; and

(f) The provisions of this Section 4.5 shall survive the Closing.

Section 4.6 Conditions Precedent to Obligations of Purchaser. The obligation of Purchaser to consummate the transaction hereunder shall be subject to the fulfillment on or before the date of Closing of all of the following conditions (the "Purchaser Conditions"), any or all of which may be waived by Purchaser in its sole and absolute discretion (for any reason or no reason):

(a) Seller shall have delivered to Purchaser all of the items required to be delivered to Purchaser pursuant to the terms of this Agreement, including but not limited to, those provided for in Section 4.2 (Seller's Obligations at Closing) hereof;

(b) As of Closing, the Property shall have all rights, entitlements and approvals necessary to permit at least 28,250 rentable square feet of medical office use and the remainder of the building for professional office use, together with parking rights for not less than two hundred

seventy-eight (278) parking spaces (inclusive of surface parking on the Property and any additional parking allocated pursuant to the Declaration Amendment (as hereinafter defined)), which shall satisfy applicable City of Irvine parking requirements for such uses. Purchaser intends to designate certain reserved spaces of CalOptima transportation vans within the surface parking areas on the Property, which location shall reasonably be agreed to by Seller and Purchaser. Seller shall reasonably cooperate with Purchaser at Purchaser's reasonable request, before and after Closing, at no material cost to Seller, in securing additional parking rights or approvals required for any future expansion of the medical office use of the Property; provided, however, Seller shall have no obligation to provide any additional parking rights or approvals to Purchaser.

(c) The Governmental Approvals shall have been obtained, or the Governmental Approvals contingency shall have been waived or deemed waived pursuant to Section 3.4.

(d) All of the representations and warranties of Seller contained in this Agreement shall be true and correct in all material respects as of the date of Closing (with appropriate modifications permitted under this Agreement); and

(e) Seller shall have performed and observed, in all material respects, all covenants and agreements of this Agreement to be performed and observed by Seller as of the date of Closing.

(f) Seller shall have obtained Lender Approval.

(g) That certain Declaration of Easements, Covenants, Conditions and Restrictions recorded November 23, 2004 as Instrument No. 2004-001045376, Official Records of Orange County, California (the "Declaration") shall have been amended by an instrument executed by all required Owners (as defined therein) and their respective mortgagees (the "Declaration Amendment") to (A) permit Purchaser's intended use of the Property as a Program of All-Inclusive Care for the Elderly (PACE) facility and related medical services, notwithstanding the use restrictions set forth in Section 4.2.1 of the Declaration; (B) allocate to the Property parking rights sufficient (together with surface parking on the Property) to satisfy the parking requirements set forth in Section 4.6(b), which additional parking allocation shall automatically revert to Seller if Purchaser (or its successor) permanently ceases to use the Property for PACE or medical services use; and (C) provide for Seller to have reasonably exercised consent rights solely with respect to the exterior design, signage, and use of the Property in a manner that could materially impact neighboring parcels or compliance with applicable law, such consent not to be unreasonably withheld, conditioned, or delayed (the "Declaration Amendment Condition"). The Declaration Amendment shall be in form and substance reasonably satisfactory to Seller and Purchaser. After the date hereof, Seller and Purchaser shall use good faith efforts to negotiate the form of the Declaration Amendment.

(h) Prior to or at Closing, Seller and Purchaser shall have entered into a partial assignment of Conditional Use Permit No. 00777287-PCPM (or such other instrument as the City of Irvine may require) allocating to the Property not less than 28,250 rentable square feet of medical office use capacity out of the aggregate 100,000 square feet of medical office conversion authorized campus-wide under such Conditional Use Permit (the "CUP Partial Assignment"). The CUP Partial Assignment shall be in form and substance reasonably satisfactory to Seller and Purchaser. After the date hereof, Seller and Purchaser shall use good faith efforts to negotiate the

form of the CUP Partial Assignment. Notwithstanding anything stated to the contrary, (i) Seller shall not be required to reduce the medical office use capacity available to Seller's retained parcels below 71,750 rentable square feet in the aggregate, and (ii) Seller shall have no obligation to incur any material cost or expense in connection therewith.

If any of the foregoing Purchaser Conditions in (a), (d), or (e) above are not satisfied on or prior to Closing (and Purchaser has not waived them in writing), then such failure shall constitute a default by Seller pursuant to Section 6.2 (Default by Seller) of this Agreement. If the Purchaser Condition in (b), (c), (f) (g), or (h) above is not timely satisfied, then Purchaser may elect, in Purchaser's sole and absolute discretion, to either (a) waive such condition, in which event the Closing shall occur as if such condition had been satisfied, or (b) terminate this Agreement in which event (i) Escrow Agent and Seller shall return the Deposit to Purchaser in accordance with Purchaser's written instructions within two (2) Business Days following Purchaser's delivery of a written termination notice to Seller and Escrow Agent, (ii) Seller and Purchaser shall each pay one half (1/2) of any escrow cancellation fees or charges, (iii) if Purchaser Condition (f) is not satisfied prior to Closing and Seller failed to terminate this Agreement pursuant to Section 5.4(c), Purchaser shall also be entitled to recover documented out-of-pocket fees and costs incurred in connection with this Agreement, up to the limit set forth in Section 6.2, (iv) if Purchaser Condition (g) (Declaration Amendment) is not satisfied prior to Closing, Purchaser shall also be entitled to recover documented out-of-pocket fees and costs incurred in connection with this Agreement, up to the limit set forth in Section 6.2, and (v) except for the obligations of the parties under this Agreement which expressly survive termination of this Agreement, the parties shall have no further rights or obligations to one another under this Agreement. For the avoidance of doubt, the failure of any Purchaser Condition in (b), (c), (f), (g), or (h) shall not constitute a default by Seller under this Agreement.

Section 4.7 Conditions Precedent to Obligations of Seller. The obligation of Seller to consummate the transaction hereunder shall be subject to the fulfillment on or before the date of Closing of all of the following conditions (the "Seller Conditions"), any or all of which may be waived by Seller in its sole and absolute discretion (for any reason or no reason):

(a) Seller shall have received the Purchase Price as adjusted as provided herein, pursuant to and payable in the manner provided for in this Agreement;

(b) Purchaser shall have delivered to Seller all of the items required to be delivered to Seller pursuant to the terms of this Agreement, including but not limited to, those provided for in Section 4.3 (Purchaser's Obligations at Closing) hereof;

(c) All of the representations and warranties of Purchaser contained in this Agreement shall be true and correct in all material respects as of the date of Closing (with appropriate modifications permitted under this Agreement); and

(d) Purchaser shall have performed and observed, in all material respects, all covenants and agreements of this Agreement to be performed and observed by Purchaser as of the date of Closing.

(e) The Declaration Amendment Condition shall have been satisfied.

If any of the foregoing Seller Conditions in (a)-(d) above are not satisfied on or prior to Closing (and Seller has not waived them in writing), then such failure shall constitute a default by Purchaser pursuant to Section 6.1 (Default by Purchaser) of this Agreement. If the Seller Condition in (e) above is not timely satisfied, then Seller may elect, in Seller's sole and absolute discretion, to terminate this Agreement in which event (i) Escrow Agent and Purchaser shall return the Deposit to Purchaser in accordance with Purchaser's written instructions within two (2) Business Days following Seller's delivery of a written termination notice to Purchaser and Escrow Agent, (ii) Seller and Purchaser shall each pay one-half (1/2) of any escrow cancellation fees or charges, (iii) Purchaser shall also be entitled to recover documented out-of-pocket fees and costs incurred in connection with this Agreement, up to the limit set forth in Section 6.2, and (iv) except for the obligations of the parties under this Agreement which expressly survive termination of this Agreement, the parties shall have no further rights or obligations to one another under this Agreement.

ARTICLE V

REPRESENTATIONS, WARRANTIES AND COVENANTS

Section 5.1 Representations and Warranties of Seller. Seller hereby makes the following representations and warranties to Purchaser as of the Effective Date, which representations and warranties shall be deemed to have been made again as of the Closing, subject to Section 4.2(f) (Seller's Obligations at Closing) hereof (together with any other representations, warranties, covenants, obligations or indemnities of Seller set forth in, or liability of Seller with respect to, this Agreement or the Ancillary Documents (as defined below), each a "Seller Obligation" and collectively, the "Seller Obligations"):

(a) Organization and Authority. Seller has been duly organized and is validly existing under the laws of the State of Delaware and is qualified to transact business in the State of California. Seller has the full right and authority to enter into this Agreement and to transfer all of the Property and to consummate or cause to be consummated the transaction contemplated by this Agreement. The person signing this Agreement, and all documents which are required to be delivered to Purchaser at Closing, on behalf of Seller is authorized to do so. At the time of Closing, this Agreement and all other documents which are required to be delivered to Purchaser at Closing, will be duly authorized, executed and delivered by Seller and are, and at the time of Closing will be, legal, valid and binding obligations of Seller, enforceable against Seller in accordance with their respective terms.

(b) Pending Actions. To Seller's knowledge, Seller has not received written notice of any action, suit, arbitration, unsatisfied order or judgment, government investigation or proceeding pending against Seller which, if adversely determined, could individually or in the aggregate materially interfere with the consummation of the transaction contemplated by this Agreement.

(c) Operating Agreements. To Seller's knowledge, the Operating Agreements listed on Exhibit C are all of the agreements concerning the operation and maintenance of the Property entered into by Seller and affecting the Property as of the Effective Date, except those operating agreements that are not assignable or are to be terminated by Seller within thirty (30) days after

the Closing, and except any agreement with Seller's property manager, which shall be terminated by Seller.

(d) Condemnation. To Seller's knowledge, Seller has received no written notice of any condemnation proceedings relating to the Property.

(e) Litigation. To Seller's knowledge, except as set forth on Exhibit I attached hereto, and except tenant eviction proceedings, tenant bankruptcies, proceedings for the collection of delinquent rentals from tenants and proceedings related to claims for personal injury or damage to property due to events occurring at the Property, Seller has not received written notice of any litigation which has been filed against Seller that arises out of the ownership of the Property and would materially affect the Property or use thereof, or Seller's ability to perform hereunder, and which would not be covered by insurance;

(f) Violations. To Seller's knowledge, except as set forth on Exhibit J attached hereto, Seller has not received written notice of any uncured violation of any federal, state or local law relating to the use or operation of the Property which would materially adversely affect the Property or use thereof. To Seller's knowledge, Seller has not received written notice from any governmental authority of (i) any violation of environmental laws relating to the Property that remains uncured, (ii) the presence of any Hazardous Substances at the Property in violation of applicable environmental laws, or (iii) any pending or threatened in writing claims relating to environmental conditions at the Property; and

Notwithstanding any contrary provision of this Agreement, (a) Seller's Obligations (as defined below) shall be qualified by and modified to reflect any information set forth in the Diligence Documents and any information discovered by or disclosed to Purchaser or otherwise known to Purchaser as of the expiration of the Inspection Period; (b) if the Closing occurs, Seller's Obligations shall be qualified by and modified to reflect any information known to Purchaser as of the Closing; and (c) Seller does not represent or warrant that the Leases will be in force or effect as of the Closing or that any tenant will not be in default thereunder. In no event shall Seller be liable to Purchaser for, or be deemed to be in default hereunder by reason of, any breach of representation or warranty which results from any change that (i) is expressly permitted under the terms of this Agreement, or (ii) occurs between the Effective Date and the date of the Closing and is beyond the reasonable control of Seller to prevent.

Section 5.2 Knowledge Defined. References to the "knowledge" of Seller shall refer only to the current actual, present knowledge of the Designated Employees (as hereinafter defined) of Seller, without any investigation or inquiry, and shall not be construed, by imputation or otherwise, to refer to the knowledge of Seller or any affiliate of Seller, to any property manager, or to any other officer, agent, manager, representative or employee of Seller or any affiliate thereof or to impose upon such Designated Employees any duty to investigate the matter to which such actual knowledge, or the absence thereof, pertains. Without limiting the foregoing, Purchaser acknowledges that the Designated Employees have not performed and are not obligated to perform any investigation or review of any files or other information in the possession of Seller, or to make any inquiry or to take any other actions in connection with the representations and warranties of Seller set forth in this Agreement. Purchaser acknowledges that the individuals named below are named solely for the purpose of defining the scope of Seller's knowledge and not for the purpose

of imposing any liability on or creating any duties running from such individual to Purchaser. Purchaser covenants that it will bring no claim, action, or lawsuit of any kind, in any circumstance, against such Designated Employees arising out of or related in any way to these representations and warranties, and such covenant will survive the Closing indefinitely. As used herein, the term "Designated Employees" shall refer to Mike Daniszewski.

Section 5.3 Survival of Seller's Post-Closing Obligations. Any of Seller's Obligations that expressly survive Closing (collectively, "Seller's Surviving Obligations") and as updated as of the Closing in accordance with the terms of this Agreement, shall survive Closing for a period of one year (the "Limitation Period"). Each of Seller's Surviving Obligations shall automatically be null and void and of no further force and effect as of the day subsequent to the last day of the Limitation Period unless, on or prior to the expiration of the Limitation Period, Purchaser shall have provided Seller with a written notice alleging that Seller is in breach of such Seller's Surviving Obligation and specifying in reasonable detail the nature of such breach. No claim for a breach of any of Seller's Surviving Obligations shall be actionable or payable if the breach in question results from or is based on a condition, state of facts or other matter which was known to Purchaser prior to Closing. Seller shall have no liability to Purchaser for a breach of any of Seller's Obligations (a) unless the valid claims for all such breaches collectively aggregate more than One Hundred Thousand and No/100 Dollars (\$100,000.00), in which event the full amount of such valid claims (including any attorneys' fees, court costs and disbursements) shall be actionable, up to the Cap (as defined in this Section), and (b) unless written notice containing a description of the specific nature of such breach shall have been given by Purchaser to Seller prior to the expiration of the Limitation Period and an action shall have been commenced by Purchaser against Seller within sixty (60) days of the date of such written notice. Purchaser agrees to first seek recovery under any insurance policies, service contracts and Leases prior to seeking recovery from Seller, and Seller shall not be liable to Purchaser if Purchaser's claim is satisfied from such insurance policies, service contracts or Leases. As used herein, the term "Cap" shall mean the total aggregate amount of Five Hundred Thousand and No/100 Dollars (\$500,000.00). Notwithstanding the foregoing, the Cap will not apply to the obligation to pay proration amounts contained in Section 4.4 (Credits and Prorations) and the obligation and indemnity contained in Section 8.1 (Brokerage Commissions). Notwithstanding anything to the contrary herein, the limitations set forth in this section (including any cap, basket, deductible or survival limitation) shall not apply to fraud, willful misconduct or intentional misrepresentation by Seller.

Section 5.4 Covenants of Seller. Seller hereby covenants with Purchaser as follows:

(a) From the Effective Date hereof until the Closing or earlier termination of this Agreement, Seller shall use reasonable efforts to operate and maintain the Property in a manner generally consistent with the manner in which Seller has operated and maintained the Property prior to the date hereof.

(b) Following the Effective Date and until the Closing, Seller shall not, without Purchaser's prior written consent, which shall not be unreasonably withheld, conditioned or delayed, enter into any new lease affecting the Property or amend, modify, renew or extend any existing Lease. Any request for consent hereunder shall be delivered to Purchaser in writing, and Purchaser shall have five (5) Business Days following receipt thereof to approve or disapprove

such request. If Purchaser fails to respond within such five (5) Business Day period, Purchaser shall be deemed to have approved such request.

(c) Seller shall, at its sole cost and expense, diligently and in good faith use commercially reasonable efforts to obtain any consent or approval required from Seller's lender in connection with the transactions contemplated by this Agreement ("Lender Approval"), including any approval required to convey the Property free and clear of any lien (including, to the extent necessary, a partial release of the Property from any Deed of Trust or other lien of such lender) or to permit Purchaser's intended use of the Property, including parking as set forth herein. Seller shall keep Purchaser reasonably informed of the status of such efforts. Any such Lender Approval shall not impose any material obligation on Purchaser or adversely affect Purchaser's intended use of the Property without Purchaser's prior written consent. Notwithstanding the foregoing, Seller shall not be required to incur material out-of-pocket costs (other than customary lender processing fees) or commence litigation in connection with obtaining Lender Approval. If Seller has not received Lender Approval reasonably acceptable to Seller prior to 5:00 p.m. (Pacific Time) on the date that is sixty (60) days after the Effective Date (the "Lender Approval Deadline"), then Seller may, in Seller's sole and absolute discretion, terminate this Agreement by delivering written notice to Purchaser prior to the Lender Approval Deadline, in which event (i) Escrow Agent and Purchaser shall return the Deposit to Purchaser in accordance with Purchaser's written instructions within two (2) Business Days following Seller's delivery of a written termination notice to Purchaser and Escrow Agent, (ii) Seller and Purchaser shall each pay one half (1/2) of any escrow cancellation fees or charges, and (iii) except for the obligations of the parties under this Agreement which expressly survive termination of this Agreement, the parties shall have no further rights or obligations to one another under this Agreement.

Section 5.5 Representations and Warranties of Purchaser. Purchaser hereby makes the following representations and warranties to Seller as of the Effective Date ("Purchaser's Representations"), which representations and warranties shall be deemed to have been made again as of the Closing, subject to Section 4.3(c) (Purchaser's Obligations at Closing) hereof:

(a) Organization and Authority. Purchaser has been duly organized and is validly existing under the laws of California and is authorized to transact business in the State of California. Purchaser has the full right and authority to enter into this Agreement and to consummate or cause to be consummated the transaction contemplated by this Agreement. The person signing this Agreement, and all documents which are required to be delivered to Seller at Closing, on behalf of Purchaser is authorized to do so. At the time of Closing, this Agreement and all other documents which are required to be delivered to Seller at Closing, will be duly authorized, executed and delivered by Purchaser and are, and at the time of Closing will be, legal, valid and binding obligations of Purchaser, enforceable against Purchaser in accordance with their respective terms.

(b) Pending Actions. There is no action, suit, arbitration, unsatisfied order or judgment, government investigation or proceeding pending against Purchaser which, if adversely determined, could individually or in the aggregate materially interfere with the consummation of the transaction contemplated by this Agreement.

(c) ERISA. (i) As of the Closing, (1) Purchaser will not be an employee benefit plan as defined in Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), which is subject to Title I of ERISA, nor a plan as defined in Section 4975(e)(1) of the Internal Revenue Code of 1986, as amended (each of the foregoing hereinafter referred to collectively as "Plan"), and (2) the assets of the Purchaser will not constitute "plan assets" of one or more such Plans within the meaning of Department of Labor ("DOL") Regulation Section 2510.3-101.

(ii) As of the Closing, if Purchaser is a "governmental plan" as defined in Section 3(32) of ERISA, the closing of the sale of the Property will not constitute or result in a violation of state or local statutes regulating investments of and fiduciary obligations with respect to governmental plans.

(iii) As of the Closing, Purchaser will be acting on its own behalf and not on account of or for the benefit of any Plan.

(iv) Purchaser has no present intent to transfer the Property to any entity, person or Plan which will cause a violation of ERISA.

(v) Purchaser shall not assign its interest under this Agreement to any entity, person, or Plan which will cause a violation of ERISA.

(d) OFAC. Seller advises Purchaser hereby that the purpose of this Section 5.5(d) is to provide to the Seller information and assurances to enable Seller to comply with the law relating to the Sanctions Lists (defined below). Either:

(i) Purchaser is a Regulated Entity (defined below), or

(ii) neither Purchaser nor any person or entity that directly or indirectly has an ownership interest in Purchaser of twenty-five percent (25%) or more, is or will be (A)(1) subject to a U.S. comprehensive sanctions program administered by the U.S. Department of Treasury, Office of Foreign Assets Control ("OFAC"), (2) named on OFAC's U.S. Specially Designated Nationals list, or (3) named on OFAC's Sectoral Sanctions Identifications list ((1), (2) and (3) collectively the "OFAC Sanctions Lists"), (B) named on any other locally required sanctions lists ("Country Lists"), or (C) named on the United Nations Security Council's sanctions list (the "U.N. List" and together with the OFAC Sanctions Lists and the Country Lists, the "Sanctions Lists").

In connection with this representation, no later than fifteen (15) Business Days prior to the expiration of the Inspection Period, with three (3) Business Days written notice to cure, Purchaser shall provide to Seller all information reasonably requested by Seller including, without limitation, organizational structural charts and organizational documents which Seller may deem to be necessary ("Purchaser Sanctions Information") in order for Seller to confirm Purchaser's compliance with the provisions of this Section 5.5(d). All Purchaser Sanctions Information provided by Purchaser to Seller in connection with this Agreement is true and complete. For purposes of this Section, a "Regulated Entity" shall mean a U.S. public company (including their documented wholly-owned subsidiaries) or any other entity, including a bank, that is regulated by the SEC, FINRA, or Federal Reserve.

(e) Purchaser has not (i) commenced a voluntary case, or had entered against it a petition, for relief under any federal bankruptcy act or any similar petition, order or decree under any federal or state law or statute relative to bankruptcy, insolvency or other relief for debtors, (ii) caused, suffered or consented to the appointment of a receiver, trustee, administrator, conservator, liquidator or similar official in any federal, state or foreign judicial or non-judicial proceeding, to hold, administer and/or liquidate all or substantially all of its property, or (iii) made an assignment for the benefit of creditors.

(f) Except with respect to any claims arising out of any breach of the representations or warranties of Seller expressly set forth in this Agreement and in the Ancillary Documents (collectively, the “Express Representations”), and except with respect to fraud, willful misconduct or intentional misrepresentation by Seller, Purchaser, for itself and its agents, affiliates, successors and assigns, hereby releases and forever discharges Seller and Seller’s Affiliates (as defined in Section 10.21 (Exculpation)), and each of their respective officers, directors, employees, agents, affiliates, trustees, shareholders, partners, members, managers, principals, successors and assigns, from any and all rights, claims and demands at law or in equity, whether direct or indirect, known or unknown, foreseen or unforeseen, at the time of this Agreement, which Purchaser has or may have in the future, arising out of or relating to any matter or thing related to the Property, including, without limitation, the documents and information referred to herein, the physical, environmental, economic or legal condition of the Property, including, without limitation, any claim for indemnification or contribution arising under the Comprehensive Environmental Response, Compensation, and Liability Act (42 U.S.C. Section 9601 et seq.) or any other environmental laws or any claim pertaining to compliance with the requirements of Section 25359.7 of the California Health and Safety Code, or any other federal, state and local, statutes, ordinances, orders, rules, regulations, guidance documents, judgments, governmental authorizations, or any other requirements of governmental authorities, as may presently exist, or as may be amended or supplemented, or hereafter enacted, relating to the presence, release, generation, use, handling, treatment, storage, transportation or disposal of Hazardous Substances (as defined below), or the protection of the environment or human, plant or animal health. With respect to the waiver and release set forth herein relating to unknown and unsuspected claims, Purchaser hereby acknowledges that such waiver and release is being made after obtaining the advice of counsel and with full knowledge and understanding of the consequences and effects of such waiver, and that such waiver is made with the full knowledge, understanding and agreement that California Civil Code Section 1542 provides as follows, and that the protections afforded by said code section are hereby waived; provided, however, that such waiver shall not apply to any fraud, willful misconduct or intentional misrepresentation by Seller:

“A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE AND THAT, IF KNOWN BY HIM OR HER, WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY.”

The foregoing waiver and release shall be deemed to be restated and made again as of the Closing.

Purchaser has read and understood the foregoing and indicated that fact by placing its initials, or the initials of an authorized agent, below:



Purchaser's initials

Purchaser further agrees that, if at any time after the Closing, any third party or any governmental agency seeks to hold Purchaser responsible for the presence of, or any loss, cost or damage associated with, Hazardous Substances in, on, above or beneath the Property or emanating therefrom or for any other environmental condition related to the Property, then Purchaser agrees that it shall not (i) implead the Seller or any affiliate thereof, (ii) bring a contribution action or similar action against the Seller or any affiliate thereof, or (iii) attempt in any way to hold the Seller or any affiliate thereof responsible with respect to any such matter. “Hazardous Substances” shall mean, collectively, any hazardous substance, extremely hazardous substance, toxic chemical, harmful substance, waste, material, pollutant or contaminant (including, without limitation, asbestos, mold polychlorinated biphenyls (“PCB's”), petroleum or petroleum by-products or wastes, flammable explosives, radioactive materials, infectious substances, materials containing lead-based paint or raw materials which include hazardous constituents) or any other substances or materials which are identified under or regulated by applicable environmental laws. The provisions of this Section 5.5(g) shall survive the Closing indefinitely.

Section 5.6 Survival of Purchaser's Representations and Warranties. The representations and warranties of Purchaser set forth in Section 5.5 (Representations and Warranties of Purchaser) hereof as updated as of the Closing in accordance with the terms of this Agreement, shall survive Closing for the Limitation Period. Purchaser shall have no liability to Seller for a breach of any representation or warranty unless written notice containing a description of the specific nature of such breach shall have been given by Seller to Purchaser prior to the expiration of the Limitation Period and an action shall have been commenced by Seller against Purchaser within sixty (60) days of the date of such written notice.

Each of the provisions of this Section 5 shall survive the Closing, but such survival shall be limited, in the case of Seller's Surviving Obligations, to the extent set forth in Section 5.3 (Survival of Seller's Post-Closing Obligations). The provisions of Section 9.2 (As-Is Sale; Disclaimers) shall apply to and shall be deemed incorporated by reference and made a part of any and all documents or instruments executed by Seller pursuant hereto or in connection herewith (collectively, the “Ancillary Documents”).

ARTICLE VI

DEFAULT AND LIMITATIONS

Section 6.1 Default by Purchaser. In the event the sale of the Property as contemplated hereunder is not consummated due to Purchaser's material default hereunder and such failure continues for a period of five (5) business days after written notice from Seller, Seller shall be entitled, as its sole remedy, to terminate this Agreement and receive the Deposit as liquidated damages for the breach of this Agreement, it being expressly understood and agreed between the parties hereto that the actual damages to Seller in the event of such a breach by Purchaser are substantial but extremely difficult to ascertain. Seller and Purchaser have used reasonable diligence to analyze and estimate the damages that Seller would suffer as a result of a Purchaser default and based on such analysis, and Purchaser and Seller hereby agree that the amount of the Deposit is a reasonable estimate thereof considering all of the circumstances existing as of the Effective Date. This Section shall survive the Closing or the earlier termination of this Agreement.

THE PARTIES ALSO ACKNOWLEDGE THAT SUCH LIQUIDATED DAMAGES ARE NOT INTENDED AS A FORFEITURE OR PENALTY WITHIN THE MEANING OF CALIFORNIA CIVIL CODE SECTION 3275 OR 3369 (OR ANY SIMILAR STATUTE), BUT INTENDED TO CONSTITUTE LIQUIDATED DAMAGES TO SELLER PURSUANT TO CALIFORNIA CIVIL CODE SECTIONS 1671, 1676 AND 1677 (AND ANY SIMILAR STATUTE). THE LIQUIDATED DAMAGES SHALL BE SELLER'S EXCLUSIVE REMEDY WITH RESPECT TO THE FAILURE TO CLOSE ESCROW FOR ANY REASON EXCEPT SELLER'S DEFAULT OR THE TERMINATION OF THIS AGREEMENT BY PURCHASER OR SELLER PURSUANT TO A RIGHT TO DO SO UNDER THE TERMS OF THIS AGREEMENT.

PURCHASER HEREBY WAIVES ANY RIGHT TO FILE ANY LIS PENDENS OR OTHER FORM OF ATTACHMENT AGAINST THE PROPERTY IN THE EVENT THAT (i) SELLER TERMINATES THIS AGREEMENT PURSUANT TO A RIGHT GIVEN TO IT HEREUNDER (ii) PURCHASER TERMINATES THIS AGREEMENT FOR ANY REASON, OR (iii) THIS AGREEMENT IS AUTOMATICALLY TERMINATED BY ITS TERMS. IF THIS AGREEMENT IS TERMINATED AS SET FORTH IN ANY OF CLAUSES (i), (ii) OR (iii) ABOVE AND THEREAFTER PURCHASER TAKES ANY ACTION WHICH INTERFERES WITH SELLER'S ABILITY TO SELL, EXCHANGE, TRANSFER, LEASE, DISPOSE OF OR FINANCE THE PROPERTY OR TAKE ANY OTHER ACTIONS WITH RESPECT THERETO (INCLUDING, WITHOUT LIMITATION, THE FILING OF ANY LIS PENDENS OR OTHER FORM OF ATTACHMENT AGAINST THE PROPERTY), THEN THE NAMED PURCHASER (AND ANY PERMITTED ASSIGNEE OF PURCHASER'S INTEREST HEREUNDER) SHALL BE LIABLE FOR ALL LOSS, COST, DAMAGE, LIABILITY OR EXPENSE (INCLUDING, WITHOUT LIMITATION, REASONABLE ATTORNEYS' FEES, COURT COSTS AND DISBURSEMENTS AND CONSEQUENTIAL DAMAGES) INCURRED BY SELLER BY REASON OF SUCH ACTION TO CONTEST BY PURCHASER.

SELLER'S INITIALS: 

PURCHASER'S INITIALS: 

Section 6.2 Default by Seller.

(a) In the event the sale of the Property as contemplated hereunder is not consummated due to Seller's material default hereunder and such failure continues for a period of five (5) business days after written notice from Purchaser, Purchaser shall be entitled, as its sole remedy, either (a) terminate this Agreement by written notice to Purchaser, whereupon Purchaser shall be entitled to receive the return of the Deposit and Seller shall reimburse Purchaser for all reasonable out-of-pocket costs and expenses actually incurred by Purchaser in connection with its due diligence and pursuit of the transaction contemplated hereby (including, without limitation, costs of third-party consultants, environmental reports, title and survey work, and reasonable attorneys' fees) in an amount not to exceed Three Hundred Thousand and NO/Dollars (\$300,000.00), or (b) seek to obtain specific performance of Seller's obligation to convey the Property to Purchaser in accordance with the terms of this Agreement. Purchaser understands and agrees that the remedy of specific performance shall not be available to enforce any other obligation of Seller hereunder. Purchaser expressly waives its rights to seek damages in the event of Seller's default hereunder except as provided for in this Agreement under Sections 4.6 and 6.2. If the sale of the Property is not consummated due to Seller's default hereunder, Purchaser shall be deemed to have elected to terminate this Agreement and receive back the Deposit and damages as provided for under Sections 4.6 and 6.2 if Purchaser fails to file suit for specific performance against Seller in a court having jurisdiction in the county and state in which the Property is located, on or before sixty (60) days following the date upon which Closing was to have occurred. If Purchaser elects to seek specific performance of this Agreement, then as a condition precedent to any suit for specific performance, Purchaser shall, on or before the date upon which Closing is to occur, time being of the essence, fully perform all of its obligations hereunder which are capable of being performed (other than those obligations that may be prevented due to Seller's default and the payment of the Purchase Price, which shall be paid as and when required by the court in the suit for specific performance). Notwithstanding the foregoing or any contrary provision of this Agreement, Purchaser shall have no right to seek specific performance if Seller shall be prohibited from performing Seller's obligations hereunder by reason of any law, regulation, or other legal requirement applicable to Seller, but not as a result of any contractual restriction, including any lender requirement or consent.

(b) In addition to and not in limitation of Seller's other rights and remedies under this Agreement, should Purchaser fail within ten (10) Business Days of a written request from Seller to indemnify and defend the Seller Related Parties from and against any loss, damage, injury, liability or claim as required solely to the extent of its indemnification obligations under Sections 3.1 (Right of Inspection) and 8.1 (Brokerage Commissions) and 10.15 (Recordation) solely to the extent arising from a filing by Purchaser not permitted under Section 10.15, ("Purchaser Indemnification Provisions"), then in any such case the Seller Related Parties may, at their option, pay any such lien, claim, demand, injury, liability or damages, or settle or discharge any action therefor or satisfy any judgment thereon, and all costs, expenses and other sums incurred by the Seller Related Parties in connection therewith (including, but not limited to, attorneys' fees, court costs and disbursements) shall be paid to the Seller Related Parties by Purchaser upon written demand, together with interest thereon at the maximum contract interest rate permitted by law from the date incurred or paid until repaid. Any default by Purchaser either in such initial failure to pay or to indemnify and defend the Seller Related Parties or such subsequent repayment to the

Seller Related Parties shall at Seller's option constitute a breach under this Agreement, which shall not be limited by the Deposit or the liquidated damages provisions set forth in Section 6.1 (Default by Purchaser) above. The indemnities provided by Purchaser in favor of the Seller Related Parties in the Purchaser Indemnification Provisions shall not require payment by the Seller Related Parties as a condition precedent. If any Seller Related Parties employ an attorney or other person or commence an action to enforce any of the provisions of this Agreement or to remove Purchaser and/or Purchaser's Representatives from the Property, Purchaser agrees to pay all costs of enforcement in connection therewith, including, but not limited to, reasonable attorneys' fees, court costs and disbursements.

(c) This Section 6.2 shall survive the Closing or the earlier termination of this Agreement.

Section 6.3 Recoverable Damages. Notwithstanding Section 6.1 (Default by Purchaser) hereof, in no event shall the provisions of Sections 6.1 (Default by Purchaser) limit the damages recoverable by Seller against Purchaser due to the Purchaser's obligation to indemnify Seller in accordance with Sections 3.1 (Right of Inspection) and 8.1 (Brokerage Commissions) of this Agreement, and Seller shall have all rights and remedies available at law or in equity with respect to such obligations. This Section 6.3 shall survive the Closing or the earlier termination of this Agreement. Except as expressly provided in such Sections, Purchaser shall not be liable for any indirect, consequential or punitive damages.

Section 6.4 Limitations. Notwithstanding any provision to the contrary contained in this Agreement or any of the documents executed by Seller pursuant hereto or in connection herewith, the maximum aggregate liability of Seller, and the maximum aggregate amount which may be awarded to and collected by Purchaser under this Agreement, including the exhibits and schedules hereto (including, without limitation, the breach of any representations, warranties, covenants and agreements contained herein), and under any Ancillary Documents (collectively, "Seller's Obligations") for which a claim is timely made by Purchaser as provided under Section 5.3 (Survival of Seller's Post-Closing Obligations) (including reasonable attorneys' fees, court costs and disbursements), except for the obligation to pay proration amounts contained in Section 4.4 (Credits and Prorations) and the obligation and indemnity contained in Section 8.1 (Brokerage Commissions), shall not exceed the Cap. Further, (a) the liability of Seller shall be limited to the assets of Seller, and in no event shall Purchaser seek satisfaction for any such liability from any of Seller's partners, members, affiliates and subsidiaries, and their respective members, stockholders, directors, officers participants, employees, consultants, brokers and agents, and (b) Purchaser waives any right to sue Seller for any consequential or punitive damages for matters arising under this Agreement (it being understood that Purchaser has waived the right to obtain indirect, incidental, special, exemplary or consequential damages in connection with any default of Seller or otherwise, which include, without limitation, loss of profits or inability to secure lenders, investors or buyers, lost opportunities, diminution in value, changes in markets, loss of tax benefits, loss of use of capital or revenue, loss of business, damage to reputation or the like). This Section shall survive the Closing or earlier termination of this Agreement.

ARTICLE VII

RISK OF LOSS

Section 7.1 Minor Damage or Condemnation. In the event of loss or damage to, or condemnation of, the Property or any portion thereof which is not "Major" (as hereinafter defined), this Agreement shall remain in full force and effect provided that Seller shall, at Seller's option, either (a) perform any necessary repairs, or (b) at the Closing, assign to Purchaser, without representation, warranty or recourse to Seller, all of Seller's right, title and interest in and to any claims and proceeds Seller may have with respect to any casualty insurance policies or condemnation awards relating to the premises in question, after deduction of Seller's expenses of collection and amounts expended by Seller in Seller's reasonable discretion to prevent further damage to the Property or to alleviate unsafe conditions at the Property caused by casualty or condemnation. In the event that Seller elects to perform repairs upon the Property, Seller shall use reasonable efforts to complete such repairs promptly and the date of Closing shall be extended a reasonable time in order to allow for the completion of such repairs. If Seller elects to assign a casualty claim to Purchaser, the Purchase Price shall be reduced by an amount equal to the lesser of the deductible amount under Seller's insurance policy or the cost of such repairs as determined in accordance with Section 7.3 hereof (Definition of "Major" Loss or Damage). Upon Closing, full risk of loss with respect to the Property shall pass to Purchaser. The provisions of this Section 7.1 supersede any law applicable to the Property governing the effect of condemnation in contracts for real property, including, without limitation, California Civil Code Section 1662.

Section 7.2 Major Damage. In the event of a "Major" loss or damage to, or condemnation of, the Property or any portion thereof, either Seller or Purchaser may terminate this Agreement by written notice to the other party, in which event the Deposit shall be returned to Purchaser, and this Agreement shall be deemed canceled and of no further force or effect, and neither party shall have any further rights or liabilities against or to the other except pursuant to the provisions of this Agreement which are expressly provided to survive the termination hereof. If neither Seller nor Purchaser elects to terminate this Agreement within ten (10) days after Seller sends Purchaser written notice of the occurrence of such Major loss, damage or condemnation (which notice shall state the cost of repair or restoration thereof as opined by an architect in accordance with Section 7.3 (Definition of "Major" Loss or Damage) hereof and the date of Closing shall be extended a reasonable period of time in order to allow for Seller to obtain such cost estimate from the architect selected pursuant to Section 7.3 (Definition of "Major" Loss or Damage) and Purchaser the 10-day period to respond), then Seller and Purchaser shall be deemed to have elected to proceed with Closing, in which event Seller shall, at Seller's option, either (a) perform any necessary repairs, or (b) assign to Purchaser at Purchaser's reasonable expense, without representation, warranty or recourse to Seller, all of Seller's right, title and interest in and to any claims and proceeds Seller may have with respect to any casualty insurance policies or condemnation awards relating to the premises in question, after deduction of Seller's expenses of collection and amounts expended by Seller in Seller's reasonable discretion to prevent further damage to the Property or to alleviate unsafe conditions at the Property caused by casualty or condemnation. In the event that Seller elects to perform repairs upon the Property, Seller shall use reasonable efforts to complete such repairs promptly and the date of Closing shall be extended a reasonable time in order to allow for the completion of such repairs. If Seller elects to assign a

casualty claim to Purchaser, the Purchase Price shall be reduced by an amount equal to the lesser of the deductible amount under Seller's insurance policy or the cost of such repairs as determined in accordance with Section 7.3 (Definition of "Major" Loss or Damage) hereof. Upon Closing, full risk of loss with respect to the Property shall pass to Purchaser. The provisions of this Section 7.2 supersede any law applicable to the Property governing the effect of condemnation in contracts for real property, including, without limitation, California Civil Code Section 1662.

Section 7.3 Definition of "Major" Loss or Damage. For purposes of Sections 7.1 (Minor Damage or Condemnation) and 7.2 (Major Damage), "Major" loss, damage or condemnation refers to the following: (a) loss or damage to the Property hereof such that the cost of repairing or restoring the premises in question to substantially the same condition which existed prior to the event of damage would be, in the opinion of an architect selected by Seller and reasonably approved by Purchaser, equal to or greater than One Million and No/100 Dollars (\$1,000,000.00), and (b) any loss due to a condemnation which permanently and materially impairs the current use of the Property. If Purchaser does not give written notice to Seller of Purchaser's reasons for disapproving an architect within five (5) Business Days after receipt of notice of the proposed architect, Purchaser shall be deemed to have approved the architect selected by Seller. The provisions of this Section 7.3 supersede any law applicable to the Property governing the effect of condemnation in contracts for real property, including, without limitation, California Civil Code Section 1662.

ARTICLE VIII

COMMISSIONS

Section 8.1 Brokerage Commissions. With respect to the transaction contemplated by this Agreement, Seller represents that its sole broker is JLL ("Seller's Broker"), and Purchaser represents that its sole broker is CBRE, Inc. ("Purchaser's Broker"). If Closing occurs, then through escrow at Closing, Seller shall cause to be paid up to two percent (2%) of the Purchase Price to Seller's Broker and up to two percent (2%) of the Purchase Price to Purchaser's Broker, pursuant to separate agreements between Seller and Seller's Broker and between Seller's Broker and Purchaser's Broker, as applicable. Each party hereto agrees that if any person or entity, other than the Seller's Broker or the Purchaser's Broker, makes a claim for brokerage commissions or finder's fees related to the sale of the Property by Seller to Purchaser, and such claim is made by, through or on account of any acts or alleged acts of said party or its representatives, said party will protect, indemnify, defend and hold the other party free and harmless from and against any and all claims, demands, causes of action, losses, costs and expenses (including reasonable attorneys' fees, court costs and disbursements) arising from any claim for commission, fees or other compensation or reimbursement for expenses made by any broker (other than Seller's Broker and Purchaser's Broker) engaged by or claiming to have dealt with the indemnifying party in connection with this Agreement or the transactions contemplated hereby. The provisions of this paragraph shall survive Closing or any termination of this Agreement.

ARTICLE IX

DISCLAIMERS AND WAIVERS

Section 9.1 No Reliance on Documents. Except as expressly stated herein, Seller makes no representation or warranty as to the truth, accuracy or completeness of any materials, data or information delivered or given by Seller or its brokers or agents to Purchaser in connection with the transaction contemplated hereby. Purchaser acknowledges and agrees that all materials, data and information delivered or given by Seller to Purchaser in connection with the transaction contemplated hereby are provided to Purchaser as a convenience only and that any reliance on or use of such materials, data or information by Purchaser shall be at the sole risk of Purchaser, except as otherwise expressly stated herein. Neither Seller, nor any other Exculpated Parties (as defined below) shall have any liability to Purchaser for any inaccuracy in or omission from any such reports.

Section 9.2 AS-IS SALE; DISCLAIMERS. EXCEPT AS EXPRESSLY SET FORTH IN THE EXPRESS REPRESENTATIONS AND EXCEPT WITH RESPECT TO FRAUD, WILLFUL MISCONDUCT OR INTENTIONAL MISREPRESENTATION BY SELLER, PURCHASER HEREBY ACKNOWLEDGES AND AGREES THAT SELLER, SELLER'S AFFILIATES, ANY OTHER PERSON ACTING ON BEHALF OF SELLER, ANY PERSON OR ENTITY WHICH PREPARED OR PROVIDED ANY OF THE MATERIALS REVIEWED BY PURCHASER IN CONDUCTING ITS DUE DILIGENCE, AND ANY DIRECT OR INDIRECT OFFICER, DIRECTOR, PARTNER, MEMBER, SHAREHOLDER, EMPLOYEE, AGENT, REPRESENTATIVE, ACCOUNTANT, ADVISOR, ATTORNEY, PRINCIPAL, AFFILIATE, CONSULTANT, CONTRACTOR, SUCCESSOR OR ASSIGN OF ANY OF THE FOREGOING PARTIES (SELLER, AND ALL OF THE OTHER PARTIES DESCRIBED IN THE PRECEDING PORTIONS OF THIS SENTENCE (OTHER THAN PURCHASER) SHALL BE REFERRED TO HEREIN COLLECTIVELY AS THE "EXCULPATED PARTIES") ARE MAKING, HAVE NOT AT ANY TIME AND WILL NOT BE DEEMED TO HAVE MADE ANY ORAL OR WRITTEN WARRANTIES OR REPRESENTATIONS OF ANY KIND OR CHARACTER, EXPRESS OR IMPLIED, BY OPERATION OF LAW, OR OTHERWISE, WITH RESPECT TO THE PROPERTY, INCLUDING, BUT NOT LIMITED TO, ANY WARRANTIES OR REPRESENTATIONS (A) AS TO HABITABILITY, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, OR (B) AS TO THE PHYSICAL, STRUCTURAL OR ENVIRONMENTAL NATURE OR CONDITION OF THE PROPERTY OR ITS COMPLIANCE WITH LAWS, OR (C) AS TO THE EXISTENCE OR NON-EXISTENCE OF PETROLEUM, ASBESTOS, LEAD PAINT, FUNGI, INCLUDING MOLD, OR OTHER MICROBIAL CONTAMINATION, HAZARDOUS SUBSTANCES OR WASTES, UNDERGROUND OR ABOVE GROUND STORAGE TANKS OR ANY OTHER ENVIRONMENTAL HAZARDS ON, UNDER OR ABOUT THE PROPERTY, OR (D) AS TO THE PERMITTED USE OF THE PROPERTY OR THE ZONING AND OTHER LAWS, REGULATIONS AND RULES APPLICABLE THERETO OR THE COMPLIANCE BY THE PROPERTY THEREWITH, OR (E) AS TO THE REVENUES AND EXPENSES GENERATED

BY OR ASSOCIATED WITH THE PROPERTY, OR AS OTHERWISE RELATING TO THE PROPERTY OR THE TRANSACTIONS CONTEMPLATED HEREIN.

EXCEPT WITH RESPECT TO ANY EXPRESS REPRESENTATIONS AND EXCEPT WITH RESPECT TO FRAUD, WILLFUL MISCONDUCT OR INTENTIONAL MISREPRESENTATION BY SELLER,, PURCHASER ACKNOWLEDGES AND AGREES THAT UPON CLOSING SELLER SHALL SELL AND CONVEY TO PURCHASER AND PURCHASER SHALL ACCEPT THE PROPERTY "AS IS, WHERE IS, WITH ALL FAULTS", BASED UPON THE CONDITION (PHYSICAL OR OTHERWISE) OF THE PROPERTY AS OF THE DATE OF CLOSING, INCLUDING WITHOUT LIMITATION, ANY NOTICES OF VIOLATIONS OF LAW OR MUNICIPAL ORDINANCES, ORDER OR REQUIREMENTS IMPOSED OR ISSUED BY ANY GOVERNMENTAL OR QUASI-GOVERNMENTAL AUTHORITY HAVING OR ASSERTING JURISDICTION, AGAINST OR AFFECTING THE PROPERTY AND ANY CONDITIONS THAT MAY RESULT IN ANY VIOLATION. PURCHASER ACKNOWLEDGES AND AGREES THAT ITS OBLIGATIONS UNDER THIS AGREEMENT SHALL NOT BE SUBJECT TO ANY FINANCING CONTINGENCY OR OTHER CONTINGENCIES OR SATISFACTION OF CONDITIONS AND PURCHASER SHALL HAVE NO RIGHT TO TERMINATE THIS AGREEMENT OR RECEIVE A RETURN OF THE DEPOSIT (OR THE ACCRUED INTEREST THEREON) EXCEPT AS EXPRESSLY PROVIDED FOR IN THIS AGREEMENT. PURCHASER HAS NOT RELIED AND WILL NOT RELY ON, AND SELLER IS NOT LIABLE FOR OR BOUND BY, ANY EXPRESS OR IMPLIED WARRANTIES, GUARANTIES, STATEMENTS, REPRESENTATIONS OR INFORMATION PERTAINING TO THE PROPERTY OR RELATING THERETO (INCLUDING SPECIFICALLY, WITHOUT LIMITATION, OFFERING PACKAGES DISTRIBUTED WITH RESPECT TO THE PROPERTY) MADE OR FURNISHED BY SELLER, THE MANAGERS OF THE PROPERTY, OR ANY REAL ESTATE BROKER OR AGENT REPRESENTING OR PURPORTING TO REPRESENT SELLER, TO WHOMEVER MADE OR GIVEN, DIRECTLY OR INDIRECTLY, ORALLY OR IN WRITING, UNLESS SPECIFICALLY SET FORTH IN THIS AGREEMENT OR ARISING FROM ANY FRAUD, WILLFUL MISCONDUCT OR INTENTIONAL MISREPRESENTATION BY SELLER. PURCHASER ALSO ACKNOWLEDGES THAT THE PURCHASE PRICE REFLECTS AND TAKES INTO ACCOUNT THAT THE PROPERTY IS BEING SOLD "AS-IS."

PURCHASER REPRESENTS TO SELLER THAT PURCHASER HAS CONDUCTED, OR WILL CONDUCT PRIOR TO CLOSING, SUCH INVESTIGATIONS OF THE PROPERTY, INCLUDING BUT NOT LIMITED TO, THE PHYSICAL AND ENVIRONMENTAL CONDITIONS THEREOF, AS PURCHASER DEEMS NECESSARY OR DESIRABLE TO SATISFY ITSELF AS TO THE CONDITION OF THE PROPERTY AND THE EXISTENCE OR NONEXISTENCE OR CURATIVE ACTION TO BE TAKEN WITH RESPECT TO ANY HAZARDOUS OR TOXIC SUBSTANCES ON OR DISCHARGED FROM THE PROPERTY, AND WILL RELY SOLELY UPON SAME AND NOT UPON ANY INFORMATION PROVIDED BY OR ON BEHALF OF SELLER OR ITS AGENTS OR EMPLOYEES WITH RESPECT THERETO, OTHER THAN THE EXPRESS REPRESENTATIONS. UPON CLOSING, PURCHASER SHALL ASSUME THE RISK THAT ADVERSE MATTERS, INCLUDING BUT NOT LIMITED TO, CONSTRUCTION DEFECTS AND ADVERSE PHYSICAL AND ENVIRONMENTAL CONDITIONS, MAY NOT HAVE BEEN REVEALED

BY PURCHASER'S INVESTIGATIONS EXCEPT WITH RESPECT TO ANY FRAUD, WILLFUL MISCONDUCT OR INTENTIONAL MISREPRESENTATION BY SELLER.

Without limiting this Section 9.2, Seller and Purchaser acknowledge that the Disclosure Statutes (as defined below) provide that a seller of real property must make certain disclosures regarding certain natural hazards potentially affecting the property, as more particularly provided therein. As used in this Agreement, "Disclosure Statutes" means, collectively, California Government Code Sections 8589.3, 8589.4 and 51183.5, California Public Resources Code Sections 2621.9, 2694 and 4136 and any other statutes that require Seller to make disclosures concerning the Property. Purchaser acknowledges that the Real Property may be located in an earthquake fault zone and/or special hazard flood area. Seller shall cause Escrow Agent to obtain and provide to Purchaser a Natural Hazard Disclosure Report for the Property (the "Report"). Purchaser hereby agrees as follows with respect to the Disclosure Statutes and the Report: (i) the delivery of the Report to Purchaser shall be deemed to satisfy all obligations and requirements of Seller under the Disclosure Statutes; (ii) Seller shall not be liable for any error or inaccuracy in, or omission from, the information in the Report; and (iii) the Report is being provided by Seller for purposes of complying with the Disclosure Statutes and shall not be deemed to constitute a representation or warranty by Seller as to the presence or absence in, at or around of the Property of the conditions that are the subject of the Disclosure Statutes. Purchaser acknowledges that (i) Seller has informed Purchaser of the requirements of California Civil Code Section 1101.5(a), which requires that on or before January 1, 2019 all noncompliant plumbing fixtures in any multifamily residential real property and in any commercial real property shall be replaced with water-conserving plumbing fixtures, and (ii) the Property may include noncompliant plumbing fixtures.

Purchaser acknowledges and agrees that the sole inquiries and investigations Seller conducted in connection with the environmental condition of the Property (other than old Phase I reports, if any, that do not disclose any recognized environmental conditions) are described in the Diligence Documents and that, for purposes of California Health and Safety Code Section 25359.7, Seller has acted reasonably in relying upon said inquiries and investigations, and the delivery of this Agreement constitutes written notice to Purchaser under such code section. Purchaser (a) acknowledges Purchaser's receipt of the foregoing notice given pursuant to Section 25359.7 of the California Health and Safety Code; (b) will be, prior to the expiration of the Inspection Period, fully aware of the matters described in the Diligence Documents; and (c) after receiving advice of Purchaser's legal counsel, waives any and all rights Purchaser may have to assert that Seller has not complied with the requirements of Section 25359.7 of the California Health and Safety Code.

Section 9.3 Survival of Disclaimers. The provisions of this Article IX shall survive Closing or any termination of this Agreement.

ARTICLE X

MISCELLANEOUS

Section 10.1 Confidentiality. Purchaser and Purchaser's Representatives shall hold in strictest confidence any and all documents, materials data and information in written, oral or other tangible or intangible forms obtained with respect to Seller, Seller's business or the Property,

whether obtained before or after the execution and delivery of this Agreement, including, without limitation, the Diligence Documents, and shall not disclose the same to others; provided, however, that it is understood and agreed that Purchaser may disclose such data and information to the employees, lenders, consultants, accountants and attorneys of Purchaser on a need to know basis to the extent necessary for Purchaser to consummate the transaction contemplated hereunder provided that such persons agree in writing to treat such data and information confidentially. Notwithstanding the foregoing, Purchaser shall have the right to disclose such information as may be required by applicable law, regulation, or pursuant to any public records request, including, without limitation, pursuant to the California Public Records Act, subject to Purchaser providing Seller with prior notice to the extent reasonably practicable. In the event this Agreement is terminated for any reason or Purchaser fails to perform hereunder, Purchaser shall promptly return to Seller any statements, documents, schedules, exhibits or other written information obtained from Seller in connection with this Agreement or the transaction contemplated herein. Notwithstanding anything to the contrary herein, Purchaser's obligation to return or destroy such materials shall not be a condition precedent to the return of the Deposit. In the event of a breach or threatened breach by Purchaser or Purchaser's Representatives of this Section 10.1, Seller shall be entitled to an injunction restraining Purchaser and Purchaser's Representatives from disclosing, in whole or in part, such confidential information. Nothing herein shall be construed as prohibiting Seller from pursuing any other available remedy at law or in equity for such breach or threatened breach. Notwithstanding the foregoing, if required for Governmental Approvals, Purchaser may disclose potential confidential information to applicable governmental agencies in connection with any applications for Governmental Approvals upon written consent of Seller.

Section 10.2 Public Disclosure. Prior to and after the Closing, any press release or other public disclosure of information with respect to the sale contemplated herein or any matters set forth in this Agreement made or released by or on behalf of Purchaser shall be subject to Seller's prior approval, which approval shall not be unreasonably withheld, conditioned or delayed; provided, however, that Purchaser may make any disclosure required by applicable law, regulation or legal process, including, without limitation, the California Public Records Act, or as required in connection with Purchaser's governmental, board or regulatory processes, without Seller's consent and without liability hereunder, and may disclose such information to the extent reasonably necessary to comply therewith. Seller and the affiliates of Seller shall have the right without Purchaser's consent, to make prior to and after the Closing press releases and other public disclosures with respect to the sale contemplated herein and matters set forth in this Agreement.

Section 10.3 Assignment. Subject to the provisions of this Section 10.3, the terms and provisions of this Agreement are to apply to, inure to the benefit of, and bind the Seller and Purchaser, and their respective permitted successors and assigns; provided, however, that none of the representations or warranties made by Seller hereunder shall inure to the benefit of any person or entity that may, after the Closing, succeed to Purchaser's interest in the Property. Purchaser may not assign or otherwise transfer this Agreement, or any of its rights or obligations under this Agreement, or any of the direct or indirect ownership interests in Purchaser, without first obtaining Seller's written approval, which approval may be given or withheld in Seller's sole and absolute discretion (for any reason or no reason), and any such attempted assignment without Seller's prior written approval shall be null and void. In the event Purchaser intends to assign its rights hereunder, (a) Purchaser shall send Seller written notice of its request at least ten (10) Business

Days prior to Closing, which request shall include the legal name and structure of the proposed assignee, the information set forth and contemplated in Section 5.5(d) (Representations and Warranties of Purchaser - OFAC) hereof, as well as any other information that Seller may reasonably request, and (b) Purchaser and the proposed assignee shall execute an assignment and assumption of this Agreement in form and substance satisfactory to Seller, and (c) in no event shall any assignment of this Agreement release or discharge Purchaser from any liability or obligation hereunder. Notwithstanding the foregoing, under no circumstances shall Purchaser have the right to assign this Agreement to any person or entity owned or controlled by an employee benefit plan if Seller's sale of the Property to such person or entity would, in the reasonable opinion of Seller's ERISA advisor, create or otherwise cause a "prohibited transaction" under ERISA, or to a person or entity that would not comply with Section 5.5(d) (Representations and Warranties of Purchaser - OFAC) hereof. Any transfer, directly or indirectly, of any stock, partnership interest or other ownership interest in Purchaser shall constitute an assignment of this Agreement.

Section 10.4 Notices. Any notice, demands, requests or other communications (collectively, "Notices") required to be given or which may be given pursuant to this Agreement shall be given in writing by (a) personal delivery, (b) reputable overnight delivery service with proof of delivery, or (c) United States Mail, postage prepaid, registered or certified mail, return receipt requested, or (d) e-mail transmission (provided that the original shall be simultaneously delivered by reputable overnight delivery service, personal delivery or United States Mail), sent to the intended addressee at the address set forth below, or to such other address or to the attention of such other person as the addressee shall have designated by written notice sent in accordance herewith, and shall be deemed to have been given upon receipt or refusal to accept delivery, or, in the case of e-mail transmission, as of the date of the e-mail transmission provided that an original is also sent to the intended addressee by means described in clauses (a), (b) or (c) above. Unless changed in accordance with the below, the addresses for notices given pursuant to this Agreement shall be as follows:

If to Seller: MIM Intersect Owner, LLC
c/o MetLife Investment Management
601 South Figueroa Street, Suite 2900,
Los Angeles, CA 90017
Attention: Mike Daniszewski
Re: Intersect
Telephone No. (213) 576-1864
Email: michael.daniszewski@metlife.com

with a copy to: MIM Intersect Owner, LLC
c/o MetLife Investment Management, LLC
425 Market Street, Suite 1050
San Francisco, CA 94105
Attention: Associate General Counsel
Re: Intersect

with a copy to: DLA Piper LLP (US)
2000 Avenue of the Stars

Suite 400 North Tower
Los Angeles, CA 90067-4704
Attention: Devan Popat
Telephone No. (310) 595.3220
Email: devan.popat@us.dlapiper.com

If to Purchaser: CalOptima Health
505 City Parkway West
Orange, CA 92868
Attention: Yunkyung Kim, COO
Email: yunkyung.kim@CalOptima.org

with a copy to: Kennaday & Leavitt, PC
400 Capital Mall, Ste 2840
Sacramento, CA 95814
Attention: Scott Schoeffel, Esq.
Telephone No.: 916-732-3060
Email: sschoeffel@kennadayleavitt.com

with a copy to: Woodruff & Smart
555 Anton Boulevard, Suite 1200
Costa Mesa, CA 92626
Attention: Mark Monachino, Esq.
Telephone No. (714) 415-1077
Email: mmonachino@woodruff.law

Any Notice sent by e-mail transmission shall be deemed given when received as confirmed by the date-stamped time of receipt on the e-mail message, provided that if the date-stamped time of receipt is later than 5:00 p.m., Pacific Time, the Notice shall be deemed received as of the next Business Day. A Notice may be given either by a party or by such party's attorney. Seller or Purchaser may designate, by not less than five (5) Business Days' notice given to the others in accordance with the terms of this Section 10.4, additional or substituted parties to whom Notices should be sent hereunder.

Section 10.5 Modifications. This Agreement cannot be changed orally, and no executory agreement shall be effective to waive, change, modify or discharge it in whole or in part unless such executory agreement is in writing and is signed by the parties against whom enforcement of any waiver, change, modification or discharge is sought.

Section 10.6 Entire Agreement. This Agreement, including the exhibits and schedules hereto, contains the entire agreement between the parties hereto pertaining to the subject matter hereof and fully supersedes all prior written or oral agreements, understandings, representations and statements, oral or written, between the parties pertaining to such subject matter.

Section 10.7 Further Assurances. Each party agrees that it will do, execute, acknowledge, and deliver any and all such other documents and take such other action, whether

prior or subsequent to Closing, as may be reasonably requested by the other party to consummate the transaction contemplated by this Agreement.

Section 10.8 Counterparts. This Agreement may be executed in counterparts, all such executed counterparts shall constitute the same agreement, and the signature of any party to any counterpart shall be deemed a signature to, and may be appended to, any other counterpart.

Section 10.9 E-Mail Signatures. In order to expedite the transaction contemplated herein, emailed .pdf copies of wet ink signatures may be used in place of original signatures on this Agreement. Seller and Purchaser intend to be bound by the wet ink signatures on the emailed .pdf document, are aware that the other party will rely on the emailed .pdf wet ink signatures, and hereby waive any defenses to the enforcement of the terms of this Agreement based on the form of signature.

Section 10.10 Severability. If any term or provision of this Agreement, or the application thereof to any person or circumstance, is determined by a court of competent jurisdiction to be invalid or unenforceable, the remainder of this Agreement shall nonetheless remain in full force and effect; provided that the invalidity or unenforceability of such provision does not materially adversely affect the benefits accruing to any party hereunder.

Section 10.11 Applicable Law. This Agreement shall be governed by and construed in accordance with the laws of the State in which the Property is located without giving effect to any conflict of laws principles thereof that may require the application of the laws of any other jurisdiction.

Section 10.12 No Third-Party Beneficiary. Except as otherwise specifically provided in this Agreement with respect to Seller's Affiliates or Seller Related Parties, the provisions of this Agreement and of the documents to be executed and delivered at Closing are and will be for the benefit of Seller and Purchaser (and their permitted successors and/or assigns) only and are not for the benefit of any third party, and accordingly, no third party shall have the right to enforce the provisions of this Agreement or of the documents to be executed and delivered at Closing.

Section 10.13 Captions. The section headings appearing in this Agreement are for convenience of reference only and are not intended, to any extent and for any purpose, to limit or define the text of any section or any subsection hereof.

Section 10.14 Construction. The parties acknowledge that the parties and their counsel have reviewed and revised this Agreement and that the normal rule of construction to the effect that any ambiguities are to be resolved against the drafting party shall not be employed in the interpretation of this Agreement or any exhibits or amendments hereto.

Section 10.15 Recordation. Neither this Agreement nor any memorandum hereof, may be recorded by any party hereto without the prior written consent of the other party hereto. Purchaser shall not file any notice of pendency of action or other instrument against the Property except in connection with an action to enforce Purchaser's rights under this Agreement, including, without limitation, an action for specific performance. Purchaser shall indemnify, defend and hold Seller and Seller Related Parties harmless from and against any and all losses, costs, damages, liens,

claims, liabilities or expenses (including, but not limited to, attorneys' fees, court costs and disbursements) arising from the filing by Purchaser of any such notice or instrument that is not permitted under this Section or is determined by a court of competent jurisdiction to have been improperly filed.

Section 10.16 Audit Rights and Reconciliation Statements. For a period of three (3) years after the Closing, Purchaser shall allow Seller and its agents and representatives access without charge to (i) all files, records, and documents delivered to Purchaser at the Closing, and (ii) the financial records and financial statements for the Property for the calendar year in which the Closing occurs and for the calendar year preceding the calendar year in which the Closing occurs, upon reasonable advance notice and at all reasonable times, to examine and to make copies of any and all such files, records, documents, and statements, which right shall survive the Closing.

Section 10.17 Waiver. No waiver by either party of any failure or refusal by the other party to comply with its obligations shall be deemed a waiver of any other or subsequent failure or refusal to so comply. No extension of time for performance of any obligation or act shall be deemed an extension of the time for performance of any other obligation or act.

Section 10.18 Jurisdiction and Venue. The parties hereto agree to submit to personal jurisdiction in the federal and state courts located in the state in which the Property is located in any action or proceeding arising out of this Agreement and further agree that the venue for any such action or proceeding shall be in the County in which the Property is located.

Section 10.19 **WAIVER OF TRIAL BY JURY. TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, SELLER AND PURCHASER HEREBY IRREVOCABLY AND UNCONDITIONALLY WAIVE ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY ACTION, SUIT OR COUNTERCLAIM ARISING IN CONNECTION WITH, OUT OF OR OTHERWISE RELATING TO THIS AGREEMENT OR THE ANCILLARY DOCUMENTS.**

Section 10.20 Consent or Approval. Except as expressly set forth herein, any consent or approval to be given hereunder (whether by Seller or Purchaser) shall not be effective unless the same shall be given in advance of the taking of the action for which consent or approval is requested and shall be in writing.

Section 10.21 Exculpation. Purchaser agrees that it does not have and will not have any claims or causes of action against any disclosed or undisclosed officer, director, employee, agent, trustee, shareholder, general partner, limited partner, member, manager, principal, parent, subsidiary or other affiliate of Seller, or any of their respective officers, directors, employees, agents, trustees, shareholders, general partners, limited partners, members, managers or principals (collectively, "Seller's Affiliates"), arising out of or in connection with this Agreement, the transactions contemplated hereby or the Ancillary Documents. Purchaser agrees to look solely to Seller and its assets for the satisfaction of any liability or obligation arising under this Agreement or any amendments thereto, the transactions contemplated hereby or the Ancillary Documents, or for the performance of any of the covenants, warranties or other agreements contained herein, any amendments hereto or in the Ancillary Documents, and further agrees not to sue or otherwise seek to enforce any personal obligation against any of Seller's Affiliates with respect to any matters

arising out of or in connection with this Agreement, any amendments hereto, the transactions contemplated hereby or the Ancillary Documents. Without limiting the generality of the foregoing provisions of this Section 10.21, Purchaser hereby unconditionally and irrevocably waives any and all claims and causes of action of any nature whatsoever it may now or hereafter have against Seller's Affiliates, and hereby unconditionally and irrevocably releases and discharges Seller's Affiliates from any and all liability whatsoever which may now or hereafter accrue in favor of Purchaser against Seller's Affiliates, in connection with or arising out of this Agreement, any amendments hereto, the transactions contemplated hereby or the Ancillary Documents.

Section 10.22 1031 Exchange. Each party agrees to cooperate with the other party (the "Exchanging Party") and any escrow holder or exchange facilitator selected by the Exchanging Party in effecting a qualifying exchange or exchanges under Section 1031 of the Internal Revenue Code undertaken by the Exchanging Party with respect to the Property, either through assignment of this Agreement by the Exchanging Party to a qualified intermediary or through other means determined by the Exchanging Party, and the non-Exchanging Party shall execute such documents as may be reasonably requested by the Exchanging Party provided that such documents shall not increase the non-Exchanging Party's obligations over those otherwise contained in this Agreement. Neither party makes any representation regarding qualification of any exchange under Section 1031 of the Internal Revenue Code and shall not be liable to the Exchanging Party in any manner whatsoever if the exchange completed in accordance with this Section 10.22 does not qualify for any reason under Section 1031 of the Internal Revenue Code. The Exchanging Party hereby agrees to indemnify, defend and hold the non-Exchanging Party harmless from and against all costs, expenses and liabilities incurred by the non-Exchanging Party in connection with any such exchange, from and against all costs, expenses and liabilities arising out of or relating to such exchange and to the extent the same would not have been incurred by the non-Exchanging Party in the absence of such exchange. Notwithstanding anything in this Section 10.22 to the contrary, it is a condition precedent to the non-Exchanging Party's obligation to cooperate with the Exchanging Party in any such exchange that: (i) no material change to the terms of this Agreement results therefrom; and the non-Exchanging Party shall not incur any out-of-pocket cost or expense (other than de minimis administrative costs), (ii) the non-Exchanging Party shall not be required to acquire or hold title to any other real property for the purpose of consummating the exchange, and (iii) consummation or accomplishment of such an exchange shall not be a condition precedent or a condition subsequent to either party's obligations under this Agreement and shall not delay the Closing or extend or modify any deadlines set forth in this Agreement.

Section 10.23 Survival/Merger. EXCEPT FOR THE OBLIGATIONS OF THE PARTIES THAT ARE EXPLICITLY STATED TO SURVIVE THE CLOSING, (A) NONE OF THE OBLIGATIONS OF THE PARTIES UNDER THIS AGREEMENT SHALL SURVIVE THE CLOSING, AND (B) THE DELIVERY OF THE DEED AND ANY OTHER DOCUMENTS AND INSTRUMENTS BY SELLER AND THE ACCEPTANCE THEREOF BY PURCHASER SHALL EFFECT A MERGER, AND BE DEEMED THE FULL PERFORMANCE AND DISCHARGE OF EVERY OBLIGATION ON THE PART OF PURCHASER AND SELLER TO BE PERFORMED HEREUNDER.

Section 10.24 Government Approvals. Except as expressly set forth in Section 3.4 (Governmental Approvals) and elsewhere in this Agreement, nothing contained in this Agreement shall be construed as authorizing Purchaser to apply for a zoning change, variance, subdivision maps, lot line adjustment or other discretionary governmental act, approval or permit with respect to the Property prior to the Closing, and Purchaser agrees not to do so without Seller's prior written approval, which approval may be withheld in Seller's sole and absolute discretion (for any reason or no reason). Purchaser agrees not to submit any reports, studies or other documents, including, without limitation, plans and specifications, impact statements for water, sewage, drainage or traffic, environmental review forms, or energy conservation checklists to any governmental agency, or any amendment or modification to any such instruments or documents prior to the Closing unless first approved by Seller, which approval shall not be unreasonably withheld, conditioned or delayed. Except for the Governmental Approvals, Purchaser's obligation to purchase the Property shall not be subject to or conditioned upon Purchaser's obtaining any variances, zoning amendments, subdivision maps, lot line adjustment, or other discretionary governmental act, approval or permit.

Section 10.25 No Joint Venture. This agreement shall not create a partnership or joint venture relationship between Purchaser and Seller.

Section 10.26 Time is of Essence. Time is of the essence with respect to all dates, times and time periods set forth in this Agreement.

Section 10.27 Survival of Miscellaneous Provisions. The terms and provisions of this Article 10 shall survive the Closing or any termination of this Agreement.

Section 10.28 Disclosure of California Civil Code Section 1101.5. In accordance with the requirements of California Civil Code Section 1101.5(e), Seller hereby discloses the following: (1) California Civil Code Section 1101.5(a) provides as follows: "(a) On or before January 1, 2019, all noncompliant plumbing fixtures in any multifamily residential real property and in any commercial real property shall be replaced with water-conserving plumbing fixtures"; and (2) to Seller's actual knowledge, the Property does not have any such noncompliant plumbing fixtures.

Section 10.29 California Natural Hazard Disclosure. Purchaser acknowledges that Seller has commissioned the Title Company or its affiliate to prepare a natural hazard disclosure statement for the Property (the "Natural Hazard Disclosure"), including the matters required by Article 1.7 of the California Civil Code (currently Section 1103 through 1103.14). Purchaser acknowledges that this transaction is not subject to such Article 1.7, but that, nevertheless, the Natural Hazard Disclosure shall serve to satisfy any and all disclosure requirements relating to the matters referenced in the Natural Hazard Disclosure; provided, however, that the Natural Hazard Disclosure is being provided for informational purposes only and shall not be deemed to limit or modify Seller's representations and warranties expressly set forth in this Agreement. Seller does not warrant or represent either the accuracy or completeness of the information in the Natural Hazard Disclosure, and Purchaser shall use same merely as a part in its overall investigation of the Property.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Effective Date.

SELLER:

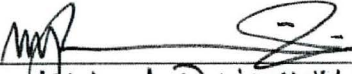
MIM INTERSECT OWNER, LLC,
a Delaware limited liability company

By: MIM Intersect REIT, LLC,
a Delaware limited liability company,
its sole and managing member

By: MIM Intersect Venture, LLC,
a Delaware limited liability company,
its sole member

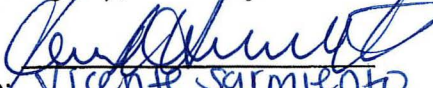
By: MIM Intersect Manager, LLC,
a Delaware limited liability company,
its manager

By: MetLife Investment Management, LLC,
a Delaware limited liability company,
its managing member

By: 
Name: Michael Dawiszewski
Title: Authorized Signatory and Director

PURCHASER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba CalOptima Health

By: 
Name: Vicente Sarmiento
Its: _____

Escrow Agent executes this Agreement below solely for the purpose of acknowledging that it agrees to be bound by the provisions of Sections 1.5 (Deposit) and 1.6 (Escrow Agent) hereof.

ESCROW AGENT:

a Chicago Title Insurance Company, a Florida corporation

By: 
Name: Kris Klask
Its: Escrow Officer

EXHIBIT A

DESCRIPTION OF LAND

THE LAND REFERRED TO HEREIN BELOW IS SITUATED IN THE CITY OF IRVINE, COUNTY OF ORANGE, STATE OF CALIFORNIA AND IS DESCRIBED AS FOLLOWS:

PARCEL A:

PARCEL 1 OF PARCEL MAP NO. 99-213, IN THE CITY OF IRVINE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP FILED IN BOOK 313, PAGES 18 TO 21, INCLUSIVE, OF PARCEL MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY.

EXCEPT ALL OIL, OIL RIGHTS, MINERALS, MINERAL RIGHTS, NATURAL GAS, NATURAL GAS RIGHTS AND OTHER HYDROCARBONS, BY WHATSOEVER NAME KNOWN THAT MAY BE WITHIN OR UNDER THE PARCEL OF LAND HEREIN ABOVE DESCRIBED, TOGETHER WITH THE PERPETUAL RIGHT OF DRILLING, MINING, EXPLORING AND OPERATING THEREFOR AND STORING IN AND REMOVING THE SAME FROM SAID LAND OR ANY OTHER LAND, INCLUDING THE RIGHT TO WHIPSTOCK OR DIRECTIONALLY DRILL AND MINE FROM LANDS OTHER THAN THOSE HEREINABOVE DESCRIBED, OIL OR GAS WELLS, TUNNELS AND SHAFTS INTO, THROUGH OR ACROSS THE SUBSURFACE OF THE LAND HEREINABOVE DESCRIBED, AND TO BOTTOM SUCH WHIPSTOCKED OR DIRECTIONALLY DRILLED WELLS, TUNNELS AND SHAFTS, UNDER AND BENEATH OR BEYOND THE EXTERIOR LIMITS THEREOF, AND TO REDRILL, RETUNNEL, EQUIP, MAINTAIN, REPAIR, DEEPEN AND OPERATE ANY SUCH WELLS OR MINES, WITHOUT, HOWEVER, THE RIGHT TO DRILL, MINE, STORE, EXPLORE AND OPERATE THROUGH THE SURFACE OR THE UPPER FIVE HUNDRED (500) FEET OF THE SUBSURFACE OF THE LAND HEREINABOVE DESCRIBED, AS RESERVED BY IRVINE INDUSTRIAL COMPLEX IN THE DEED RECORDED MAY 22, 1975, IN BOOK 11409, PAGE 122, AND IN THE DEED RECORDED JANUARY 21, 1974, IN BOOK 11060, PAGE 240, BOTH OF OFFICIAL RECORDS.

PARCEL B:

NON-EXCLUSIVE EASEMENTS FOR PEDESTRIAN AND VEHICULAR INGRESS, EGRESS AND USE AND INSTALLATION, OPERATION, FLOW AND PASSAGE, USE, MAINTENANCE, REPAIR, RELOCATION AND REMOVAL OF UTILITY LINES, ALL AS MORE PARTICULARLY DESCRIBED IN, AND SUBJECT TO THE TERMS AND PROVISIONS SET FORTH IN THAT CERTAIN "DECLARATION OF EASEMENTS" EXECUTED BY LBA-VF I IRVINE PLAZA, LLC, A DELAWARE LIMITED LIABILITY COMPANY, RECORDED MAY 4, 2000, AS INSTRUMENT NO. 2000-0233619 OF OFFICIAL RECORDS OF ORANGE COUNTY, CALIFORNIA.

PARCEL C:

NON-EXCLUSIVE EASEMENTS FOR (I) PASSAGE AND ACCOMMODATION OF PEDESTRIAN INGRESS AND EGRESS; (II) UTILITIES; (III) VEHICULAR AND

PEDESTRIAN INGRESS AND EGRESS TO AND FROM VON KARMAN AVENUE FOR PASSAGE AND PARKING OF VEHICLES, AND (IV) INSTALLATION, OPERATION, FLOW, PASSAGE, USE, MAINTENANCE, REPAIR, RELOCATION AND REMOVAL OF SANITARY SEWERS, STORM DRAINS, WATERMAINS, ELECTRICAL POWER LINES, CABLE TELEVISION LINES, TELEPHONE LINES, HEATING, VENTILATION AND AIR CONDITIONING LINES, FIRE SERVICE, WATER LINES AND OTHER UTILITY LINES, AS MORE PARTICULARLY DESCRIBED IN THAT CERTAIN EASEMENT AGREEMENT DATED OCTOBER 11, 1999 AS RECORDED ON OCTOBER 15, 1999, AS INSTRUMENT NO. 1999-0729557 OF OFFICIAL RECORDS OF ORANGE COUNTY CALIFORNIA.

EXHIBIT B
LIST OF PERSONAL PROPERTY

None

Exhibit B – Page 1

1630167624.11

EXHIBIT C
LIST OF OPERATING AGREEMENTS

None

Exhibit C – Page 1

1630167624.11

EXHIBIT D

LIST OF ENVIRONMENTAL REPORTS

Phase I Environmental Site Assessment dated April 15, 2024, prepared by SCS Engineers

EXHIBIT E
FORM OF DEED

RECORDING REQUESTED BY:

[]

WHEN RECORDED, MAIL THIS DEED TO:

MAIL ALL TAX STATEMENTS TO:

APN: _____

(Space Above For Recorder's Use)

THIS CONVEYANCE IS EXEMPT FROM DOCUMENTARY TRANSFER TAX AND RECORDING FEES PURSUANT TO CALIFORNIA REVENUE AND TAXATION CODE SECTION 11922 AND GOVERNMENT CODE SECTIONS 6103 AND 27383 BECAUSE GRANTEE IS A PUBLIC AGENCY ACQUIRING TITLE.

GRANT DEED

FOR VALUABLE CONSIDERATION, receipt of which is hereby acknowledged, _____, a _____ ("Grantor"), does hereby GRANT to _____, a _____ ("Grantee"), all of that certain real property located in the City of Irvine, County of Orange, State of California, more particularly described on Exhibit A attached hereto and incorporated herein by this reference (the "**Land**"), together with any and all structures and improvements located thereon, all of Grantor's right, title and interest in and to the rights, benefits, privileges, easements, tenements, hereditaments and appurtenances, solely to the extent belonging or appertaining to, or solely benefiting, the Land (collectively, the "**Property**").

This conveyance is made subject to all of those matters, liens and encumbrances of record, and all matters that would be revealed by a physical inspection and/or survey of the Property.

IN WITNESS WHEREOF, Grantor has caused this instrument to be executed
_____, 20__.

“GRANTOR”:

_____,
a _____

By: _____

Name: _____

Title: _____

[ACKNOWLEDGEMENTS AND LEGAL DESCRIPTION TO BE ATTACHED]

EXHIBIT F

FORM OF BILL OF SALE

KNOW ALL MEN BY THESE PRESENTS, that _____, a _____ (the “**Seller**”), for and in consideration of the sum of Ten Dollars and other valuable consideration to it in hand paid by _____, a _____ (the “**Purchaser**”), the receipt and sufficiency of which are hereby acknowledged, in connection with the sale of the Land (as defined below) hereby grants, assigns, transfers conveys, and delivers unto said Purchaser all of Seller’s right, title and interest in and to the “**Personal Property**”, as such term is defined in that certain Purchase and Sale Agreement, dated as of [____], between Seller and Purchaser (the “**Purchase Agreement**”), located upon the land described in Schedule 1 attached hereto and hereby made a part hereof (the “**Land**”) or within the improvements located thereon, including, without limitation, any and all appliances, furniture, carpeting, draperies and curtains, tools and supplies, and other items of personal property owned by Seller (excluding cash and any software), used exclusively in connection with the operation of the Land and improvements. As set forth in the Purchase Agreement, which is hereby incorporated by reference as if herein set out in full and except as set forth herein, the property conveyed hereunder is conveyed by Seller and accepted by Purchaser **AS IS, WHERE IS, AND WITHOUT ANY WARRANTIES OF WHATSOEVER NATURE, EXPRESS OR IMPLIED, EXCEPT AS EXPRESSLY SET FORTH IN THE PURCHASE AGREEMENT, IT BEING THE INTENTION OF SELLER AND PURCHASER EXPRESSLY TO NEGATE AND EXCLUDE ALL WARRANTIES, INCLUDING, WITHOUT LIMITATION, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR ANY PARTICULAR PURPOSE, WARRANTIES CREATED BY ANY AFFIRMATION OF FACT OR PROMISE OR BY ANY DESCRIPTION OF THE PROPERTY CONVEYED HEREUNDER, OR BY ANY SAMPLE OR MODEL THEREOF, AND ALL OTHER WARRANTIES WHATSOEVER CONTAINED IN OR CREATED BY THE CALIFORNIA UNIFORM COMMERCIAL CODE.** In addition, the covenants, agreements, and limitations (including, but not limited to, the limitations provided in Sections 5.3 (Survival of Seller’s Post-Closing Obligations), 5.5(g) (Representations and Warranties of Purchaser), 6.4 (Limitations), 9.2 (As-Is Sale; Disclaimers), 10.21 (Exculpation) and 10.23 (Survival/Merger) of the Purchase Agreement) provided in the Purchase Agreement with respect to the property conveyed hereunder are hereby incorporated herein by this reference as if herein set out in full.

The terms of Sections 10.4 (Notices), 10.8 (Counterparts), 10.11 (Applicable Law), 10.19 (Waiver of Trial by Jury), and 10.20 (Consent or Approval) of the Purchase Agreement are incorporated herein by reference as if fully restated herein.

TO HAVE AND TO HOLD all of said personal property unto Purchaser, its successors and assigns, to its own use forever.

IN WITNESS WHEREOF, Seller has executed this Bill of Sale as of the ____ day of _____, 2____.

_____,
a _____

By: _____
Name: _____
Title: _____

[ACKNOWLEDGEMENT AND/OR WITNESSES TO BE
ADDED IF REQUIRED UNDER APPLICABLE STATE LAW]

SCHEDULE "1"
LEGAL DESCRIPTION
[To be attached]

EXHIBIT G

FORM OF ASSIGNMENT OF CONTRACTS

This **ASSIGNMENT AND ASSUMPTION OF CONTRACTS AND INTANGIBLES** (the "Assignment") is made as of the _____ day of _____, 2____, between _____, a _____, ("Assignor") and _____, a _____ ("Assignee").

For and in consideration of the sum of Ten Dollars (\$10.00) and other valuable consideration to it in hand paid by Assignee to Assignor, the conveyance by Assignor to Assignee of all that certain real property being particularly described on Schedule 1 attached hereto and incorporated herein by this reference, more commonly known as _____ located in the City of _____, County of _____, State of _____ (the "Property"), and the mutual covenants herein contained, the receipt and sufficiency of the foregoing consideration being hereby acknowledged by the parties hereto, Assignor hereby assigns, transfers, sets over and conveys to Assignee all of Assignor's right, title and interest, to the extent assignable, in, to and under any and all of the following, to wit:

- (iv) the contracts and agreements listed and described on Schedule 2 attached hereto and incorporated herein by this reference (the "Contracts"),
- (ii) all existing warranties and guaranties (express or implied) issued to Assignor in connection with the improvements or the personal property being conveyed to Assignee by Bill of Sale on the date hereof,
- (iii) all existing permits, licenses, approvals and authorizations issued by any governmental authority in connection with the Property, and
- (iv) the non-exclusive right to the name "_____."

All items described in (ii), (iii) and (iv) above are hereinafter collectively referred to as "Intangible Property."

Assignee does hereby assume and agree to perform all of Assignor's obligations under the Contracts and Intangible Property accruing from and after the date hereof. In addition, the covenants, agreements, and limitations (including, but not limited to, the limitations provided in Sections 5.3 (Survival of Seller's Post-Closing Obligations), 5.5(g) (Representations and Warranties of Purchaser), 6.4 (Limitations), 9.2 (As-Is Sale; Disclaimers), 10.21 (Exculpation) and 10.23 (Survival/Merger) of that certain Purchase and Sale Agreement, dated as of [____], between Assignor and Assignee (the "Purchase Agreement") of the Purchase Agreement are hereby incorporated herein by this reference as if herein set out in full, with respect to any alleged breach by or on the part of Assignor of any representation, warranty, covenant undertaking, indemnity or agreement contained in this Assignment.

This Assignment shall be binding upon and inure to the benefit of Assignor and Assignee and their respective heirs, executors, administrators, successors and assigns.

This Assignment may be executed in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

The terms of Sections 10.4 (Notices), 10.8 (Counterparts), 10.11 (Applicable Law), 10.19 (Waiver of Trial by Jury), and 10.20 (Consent or Approval) of the Purchase Agreement are incorporated herein by reference as if fully restated herein.

IN WITNESS WHEREOF, Assignor and Assignee have each executed this Assignment as of the date first written above.

ASSIGNOR:

_____, a _____

By: _____

Name: _____

Title: _____

ASSIGNEE:

_____ a _____

By: _____

Name: _____

Title: _____

[ADD STATE SPECIFIC ACKNOWLEDGEMENTS AND/OR
WITNESSES FOR ASSIGNOR AND ASSIGNEE]

SCHEDULE "1"
LEGAL DESCRIPTION

SCHEDULE "2"
CONTRACTS

[To be attached]

EXHIBIT H

FORM OF FIRPTA CERTIFICATE

CERTIFICATE REGARDING FOREIGN INVESTMENT
IN REAL PROPERTY TAX ACT

(ENTITY TRANSFEROR)

Section 1445 of the Internal Revenue Code provides that a transferee (purchaser) of a U.S. real property interest must withhold tax if the transferor (seller) is a foreign person. To inform the transferee (purchaser) that withholding of tax is not required upon the disposition of a U.S. real property interest by _____, a _____ ("Transferor") Transferor hereby certifies:

1. Transferor is not a foreign corporation, foreign partnership, foreign trust, foreign estate or a disregarded entity (as those terms are defined in the Internal Revenue Code and Income Tax Regulations).
2. Transferor is not a disregarded entity as defined in Section 1.1445-2(b)(2)(iii).
3. Transferor's Federal Employer Identification Number is _____.
4. Transferor's office address is:

_____; and

5. The address or description of the property which is the subject matter of the disposition is _____.

Transferor understands that this certification may be disclosed to the Internal Revenue Service by transferee and that any false statement contained herein could be punished by fine, imprisonment, or both.

Transferor declares that it has examined this certification and to the best of its knowledge and belief, it is true, correct and complete, and further declares that the individual executing this certification on behalf of Transferor has full authority to do so.

_____, a _____

By: _____

Name: _____

Title: _____

Dated: _____

EXHIBIT I
LIST OF SPECIFIED LITIGATION

None

EXHIBIT J
LIST OF VIOLATION NOTICES

None

FIRST AMENDMENT TO PURCHASE AND SALE AGREEMENT

THIS FIRST AMENDMENT TO PURCHASE AND SALE AGREEMENT (this “**First Amendment**”) is made as of August 10, 2026, by and between **MIM INTERSECT OWNER, LLC**, a Delaware limited liability company (“**Seller**”), and **ORANGE COUNTY HEALTH AUTHORITY**, a public agency, dba CalOptima Health (“**Purchaser**”).

RECITALS

A. WHEREAS, Seller and Purchaser are parties to that certain Purchase and Sale Agreement dated as of June 11, 2026 (the “**Purchase Agreement**”). All initially-capitalized terms not otherwise defined herein shall have the meanings set forth in the Purchase Agreement unless the context clearly indicates otherwise.

B. WHEREAS, Seller and Purchaser have agreed to provide (a) a limited inspection period to permit Purchaser to resolve outstanding issues concerning ownership, control, access, maintenance, and operation of the shared fire-suppression system serving or affecting the Property (the “**Fire Suppression System Matter**”); and (b) a reduction of the Purchase Price, in each case, as set forth below.

C. WHEREAS, Seller and Purchaser have agreed to modify the terms of the Purchase Agreement as set forth in this First Amendment.

NOW, THEREFORE, for valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intended to be legally bound, Seller and Purchaser agree as follows:

1. Recitals. The Recitals set forth above are hereby incorporated herein by reference as if the same were fully set forth herein.

2. Extension of Inspection Period. Notwithstanding anything stated to the contrary in the Purchase Agreement, the expiration of the Inspection Period is hereby extended until 5:00 p.m. (Pacific Time) on August 17, 2026.

3. Extension of Lender Approval Deadline. Notwithstanding anything stated to the contrary in the Purchase Agreement, the Lender Approval Deadline is hereby extended until 5:00 p.m. (Pacific Time) on August 17, 2026.

4. Effectiveness of Agreement. Except as modified by this First Amendment, all the terms of the Purchase Agreement shall remain unchanged and in full force and effect.

5. Counterparts; E-Signatures. This First Amendment may be executed in two or more counterparts, each of which shall be deemed an original, and it shall not be necessary in making proof of this First Amendment to produce or account for more than one such counterpart. Documents executed, scanned and transmitted electronically and electronic signatures shall be deemed original signatures for purposes of this First Amendment and all matters related thereto, with such scanned and electronic signatures having the same legal effect as original signatures.

This First Amendment, and any other document necessary for the consummation of the transaction contemplated by this First Amendment, may be accepted, executed or agreed to through the use of an electronic signature in accordance with the Electronic Signatures in Global and National Commerce Act, Title 15, United States Code, Sections 7001 et seq., the Uniform Electronic Transaction Act and any applicable state law. Any document accepted, executed or agreed to in conformity with such laws will be binding on each party as if it were physically executed.

6. Successors and Assigns. All of the terms and conditions of this First Amendment shall apply to benefit and bind the successors and assigns of the respective parties.

[SIGNATURES ON NEXT PAGE]

IN WITNESS WHEREOF, Seller and Purchaser have entered into this First Amendment to Purchase and Sale Agreement and Escrow Instructions as of the date first above stated.

SELLER:

MIM INTERSECT OWNER, LLC,
a Delaware limited liability company

By: MIM Intersect REIT, LLC,
a Delaware limited liability company,
its sole and managing member

By: MIM Intersect Venture, LLC,
a Delaware limited liability company,
its sole member

By: MIM Intersect Manager, LLC,
a Delaware limited liability company,
its manager

By: MetLife Investment Management, LLC,
a Delaware limited liability company,
its managing member

By: 
Name: Michael Daniszewski
Title: Authorized Signatory and Director

PURCHASER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba CalOptima Health

By: _____
Name: _____
Its: _____

IN WITNESS WHEREOF, Seller and Purchaser have entered into this First Amendment to Purchase and Sale Agreement and Escrow Instructions as of the date first above stated.

SELLER:

MIM INTERSECT OWNER, LLC,
a Delaware limited liability company

By: MIM Intersect REIT, LLC,
a Delaware limited liability company,
its sole and managing member

By: MIM Intersect Venture, LLC,
a Delaware limited liability company,
its sole member

By: MIM Intersect Manager, LLC,
a Delaware limited liability company,
its manager

By: MetLife Investment Management, LLC,
a Delaware limited liability company,
its managing member

By: _____
Name:
Title: Authorized Signatory and Director

PURCHASER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba CalOptima Health

By: 
Name: Vicente Sarmiento
Its: Board of Directors, Chair

SECOND AMENDMENT TO PURCHASE AND SALE AGREEMENT

THIS SECOND AMENDMENT TO PURCHASE AND SALE AGREEMENT (this “**First Amendment**”) is made as of August 17, 2026, by and between **MIM INTERSECT OWNER, LLC**, a Delaware limited liability company (“**Seller**”), and **ORANGE COUNTY HEALTH AUTHORITY**, a public agency, dba CalOptima Health (“**Purchaser**”).

RECITALS

A. WHEREAS, Seller and Purchaser are parties to that certain Purchase and Sale Agreement dated as of June 11, 2026, as amended by that certain First Amendment to Purchase and Sale Agreement dated as of August 10, 2026 (collectively, the “**Purchase Agreement**”). All initially-capitalized terms not otherwise defined herein shall have the meanings set forth in the Purchase Agreement unless the context clearly indicates otherwise.

B. WHEREAS, Seller and Purchaser have agreed to provide (a) a limited inspection period to permit Purchaser to resolve outstanding issues concerning ownership, control, access, maintenance, and operation of the shared fire-suppression system serving or affecting the Property (the “**Fire Suppression System Matter**”); and (b) a reduction of the Purchase Price, in each case, as set forth below.

C. WHEREAS, Seller and Purchaser have agreed to modify the terms of the Purchase Agreement as set forth in this Second Amendment.

NOW, THEREFORE, for valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intended to be legally bound, Seller and Purchaser agree as follows:

1. Recitals. The Recitals set forth above are hereby incorporated herein by reference as if the same were fully set forth herein.

2. Inspection Period Approval; Fire Suppression Inspection Period.

(a) **Waiver of Inspection Period; Inspection Period Approval Notice**. Notwithstanding anything to the contrary in the Purchase Agreement, except for the limited rights expressly provided in this Section 2 with respect to the Fire Suppression System Matter, (i) the Inspection Period expired as of August 17, 2026 (“**Inspection Period Expiration Date**”); and (ii) except as expressly set forth in the Purchase Agreement, Purchaser shall have no further right to reopen, revive, or exercise any inspection, title, survey, diligence, or termination right that expired with the Inspection Period, including, without limitation, such termination rights pursuant to Sections 2.2 or 3.3 of the Purchase Agreement. Purchaser’s execution and delivery of this Second Amendment constitutes the Inspection Period Approval Notice pursuant to Section 1.5(a) of the Purchase Agreement for all matters other than the Fire Suppression System Matter. Notwithstanding the foregoing and for the avoidance of doubt, nothing in this Second Amendment or Purchaser’s Inspection Period Approval Notice shall waive, modify, satisfy or otherwise affect the Governmental Approvals contingency under Section 3.4, any Purchaser Condition under Section 4.6 of the Purchase Agreement, or Seller’s obligations with respect to title matters

previously objected to by Purchaser and agreed by Seller or the Title Company to be cured, removed or otherwise satisfied at or before Closing.

(b) **Fire Suppression Inspection Period.** Notwithstanding the expiration of the Inspection Period, Purchaser shall have through September 7, 2026, at 5:00 p.m. (Pacific Time) (the “**Fire Suppression Inspection Deadline**”) for the sole purpose of reviewing the Fire Suppression System Matter (such period, the “**Fire Suppression Inspection Period**”). The Fire Suppression Inspection Period shall not extend, revive, or reinstate any other Inspection Period right, contingency, or termination right under the Purchase Agreement. On or before the Fire Suppression Inspection Deadline, Purchaser may elect to terminate the Purchase Agreement by providing written notice to Seller (such notice, the “**Fire Suppression Inspection Period Termination Notice**”) solely on account of Purchaser’s good faith determination that the Fire Suppression System Matter is unsatisfactory for its purposes; provided, however, that Purchaser shall not deliver or rely upon a Fire Suppression Inspection Period Termination Notice as a pretext to terminate the Purchase Agreement based on any matter other than the Fire Suppression System Matter. If Purchaser fails to timely deliver the Fire Suppression Inspection Period Termination Notice, then (i) the Fire Suppression System Matter shall be conclusively deemed approved by Purchaser, (ii) Purchaser shall be deemed to have elected to proceed with the purchase of the Property, and (iii) the Deposit shall remain non-refundable in accordance with Section 1.5(b) of the Purchase Agreement; accordingly, Purchaser shall have no further right to terminate the Purchase Agreement pursuant to this Section 2 or Sections 2.2 or 3.3 of the Purchase Agreement. If Purchaser timely delivers the Fire Suppression Inspection Period Termination Notice, then the Purchase Agreement shall terminate, and Escrow Agent shall promptly return the Deposit, excluding the Independent Contract Consideration, to Purchaser in accordance with the Purchase Agreement (notwithstanding that such amounts otherwise became non-refundable pursuant to Section 2(c) hereof), and neither party shall have any further rights or obligations under the Purchase Agreement except those that expressly survive termination. For the avoidance of doubt, the termination right and related return of the Deposit expressly provided in this Section 2(b) constitute the limited exception under this Section 2 to the otherwise non-refundable treatment of the Deposit, subject to Section 1.5(b) of the Purchase Agreement.

(c) **Additional Deposit.** Purchaser shall deposit the Additional Deposit with Escrow Agent within two (2) Business Days after the Fire Suppression Inspection Deadline if the Purchase Agreement is not terminated, and the Deposit shall be non-refundable to Purchaser except as expressly provided Section 1.5(b) of the Purchase Agreement.

3. Extension of Lender Approval Deadline. Notwithstanding anything stated to the contrary in the Purchase Agreement, the Lender Approval Deadline is hereby extended until 5:00 p.m. (Pacific Time) on September 7, 2026.

4. Purchase Price. The Purchase Price set forth in Section 1.3 of the Purchase Agreement is hereby decreased to TWENTY-NINE MILLION FORTY-FOUR THOUSAND FIVE HUNDRED AND 00/100 DOLLARS (\$29,044,500.00).

5. Effectiveness of Agreement. Except as modified by this Second Amendment, all the terms of the Purchase Agreement shall remain unchanged and in full force and effect.

6. **Counterparts; E-Signatures.** This Second Amendment may be executed in two or more counterparts, each of which shall be deemed an original, and it shall not be necessary in making proof of this Second Amendment to produce or account for more than one such counterpart. Documents executed, scanned and transmitted electronically and electronic signatures shall be deemed original signatures for purposes of this Second Amendment and all matters related thereto, with such scanned and electronic signatures having the same legal effect as original signatures. This Second Amendment, and any other document necessary for the consummation of the transaction contemplated by this Second Amendment, may be accepted, executed or agreed to through the use of an electronic signature in accordance with the Electronic Signatures in Global and National Commerce Act, Title 15, United States Code, Sections 7001 et seq., the Uniform Electronic Transaction Act and any applicable state law. Any document accepted, executed or agreed to in conformity with such laws will be binding on each party as if it were physically executed.

7. **Successors and Assigns.** All of the terms and conditions of this Second Amendment shall apply to benefit and bind the successors and assigns of the respective parties.

[SIGNATURES ON NEXT PAGE]

IN WITNESS WHEREOF, Seller and Purchaser have entered into this Second Amendment to Purchase and Sale Agreement and Escrow Instructions as of the date first above stated.

SELLER:

MIM INTERSECT OWNER, LLC,
a Delaware limited liability company

By: MIM Intersect REIT, LLC,
a Delaware limited liability company,
its sole and managing member

By: MIM Intersect Venture, LLC,
a Delaware limited liability company,
its sole member

By: MIM Intersect Manager, LLC,
a Delaware limited liability company,
its manager

By: MetLife Investment Management, LLC,
a Delaware limited liability company,
its managing member

By: 
Name: Michael Daniszewski
Title: Authorized Signatory and Director

PURCHASER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba CalOptima Health

By: _____
Name: _____
Its: _____

IN WITNESS WHEREOF, Seller and Purchaser have entered into this Second Amendment to Purchase and Sale Agreement and Escrow Instructions as of the date first above stated.

SELLER:

MIM INTERSECT OWNER, LLC,
a Delaware limited liability company

By: MIM Intersect REIT, LLC,
a Delaware limited liability company,
its sole and managing member

By: MIM Intersect Venture, LLC,
a Delaware limited liability company,
its sole member

By: MIM Intersect Manager, LLC,
a Delaware limited liability company,
its manager

By: MetLife Investment Management, LLC,
a Delaware limited liability company,
its managing member

By: _____

Name:

Title: Authorized Signatory and Director

PURCHASER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba CalOptima Health

By: 

Name: Vicente Sarmiento

Its: Board of Directors, Chair